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# RELATIONAL AUTONOMY AS AN ESSENTIAL COMPONENT OF PATIENT-CENTERED CARE

CAROLYN ELLS, MATTHEW R. HUNT, AND JANE CHAMBERS-EVANS

## Abstract

Despite enthusiasm for patient-centered care, the practice of patient-centered care is proving challenging. Further, it is curious that the literature about this subject does not explicitly address patient autonomy, since (1) patients guide care in patient-centered care, and (2) respect for patient autonomy is a prominent health-care value. We argue that by explicitly adopting a relational conception of autonomy as an essential component, patient-centered care becomes more coherent, is strengthened, and could help practitioners to make better use of a principle of respect for autonomy. Hence, its use appears promising to narrow the theory–practice gap.

Over the past decade, patient-centered care has become increasingly prominent in discussions of health-care practice, policy, and organization. Patient-centered care is a holistic concept whereby health professionals individualize their

encounters with each patient (Stewart 2001). Decision-making strategies, recommendations, and plans of care are all devised and acted upon in relation to the particular patient. The patient is assumed to have a unique configuration of elements comprising her identity, illness experience, and physical, social, and environmental context. While partnership is understood as essential for the therapeutic encounter in a patient-centered approach, the patient herself is seen as guiding the care that she receives. However, the implementation of patient-centered care has been challenging in important respects, resulting in a gap between theory and practice.

In this article, we argue that patient-centered care can be improved by explicitly integrating a feminist formulation of autonomy, called *relational autonomy*, as an essential component. In the sections that follow, (1) We describe patient-centered care and its challenges in practice; (2) We present a worry that although respect for patient autonomy is one of the most prominent ethical principles of health professionals, a historical conception of autonomy may linger in practice with some health-care professionals (despite its lack of support in the dominant bioethics literature and its incongruence with patient-centered care); (3) We propose relational autonomy as an alternate formulation of autonomy that health-care professionals would recognize as consistent with patient-centered care; (4) We argue that theorists explicitly adopt relational autonomy as an essential component of patient-centered care (since relational autonomy provides a better fit with assumptions of and commitment to patient-centered care, enables a more coherent theory of patient-centered care, strengthens patient-centered care, and provides a rationale to justify steps to create conditions that are autonomy promoting); and (5) We consider the potential our proposal has for helping to counter some of the existing challenges in implementing patient-centered care.

### **Patient-centered care and its challenges in practice**

By putting the particular patient, not the average patient, at the center of care planning, and having the flexibility to respond differently to different patients, patients and health professionals work in partnership to develop and act on a patient-centered care plan that emanates from the particular patient's goals, preferences, and capabilities. In patient-centered care, the health professional's approach to a patient needs to acknowledge the conditions that shape what is meaningful to the patient. Caring in this way helps people remain connected to that which is meaningful to them and gives purpose to their lives (Benner and Wrubel 1989).

While there is some variation among definitions or descriptions of patient-centered care, the elements of shared decision making and control between health professionals and patients, as well as consideration of the patient in the fullness of her life and social context, are consistently present. For example, in a Cochrane review of published research, “Patient-centered care was defined as a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease)” (Lewin et al. 2009, 3). In accord with this definition, one observational study revealed that patient-centered practice involves communication and partnership, personal relationship, positive approach, health promotion, and interest in effect on patient’s life (Little et al. 2001b). That is, health professionals (in this study, general practice physicians) practicing patient-centered care are sympathetic to and interested in the patient’s concerns and expectations, seek to be a partner with the patient in understanding his or her emotional needs and promoting the patient’s health, relate to the patient in a responsive and enabling manner, and take an obvious interest in the effect of their relationship and partnership on the patient. In this study, the presence of these features of patient-centeredness reliably predicted greater patient satisfaction, less symptom burden, and lower rates of referral (Little et al. 2001b).

Nursing models (such as the McGill model of nursing [Gottlieb and Ezer 1997]),<sup>1</sup> nursing schools,<sup>2</sup> medical schools,<sup>3</sup> health-care institutions,<sup>4</sup> medical organizations,<sup>5</sup> and health professionals from various disciplines<sup>6</sup> now advocate patient-centered care. Studies also show patients and families to be supportive of patient-centered care (Law, Baptiste, and Mills 1995; McKinstry 2000; Little et al. 2001a; Lewin et al. 2009).

Evidence has shown that improvements to health-care practice (particularly those that address consultation style, empathy, and response to emotional problems) can significantly increase patient centeredness in consultation processes (Lewin et al. 2009). Despite this evidence, and despite strong ethical bases and enthusiasm for patient-centered care, its use in practice is proving challenging (Little et al. 2001b; Ponte et al. 2003). Five factors contribute to this challenge: ambiguity in the definition and key components of patient-centered care; narrow application of the model in the literature; paucity of empirical studies that directly target patient-centered care; several features of clinical education and practice; and the organization and structure of health-care settings. Brief descriptions of

these factors follow. The analysis in this paper focuses on the first two contributing factors and offers some suggestions for addressing the latter factors.

Misunderstandings and disagreement about what patient-centered care entails can lead to difficulty in applying it to practice. In a recent dimensional analysis of patient-centered care, Jennifer Hobbs (2009) examined the usage of this concept in the literature. She identified ambiguity in how patient-centered care is defined and interpreted<sup>7</sup> and concluded that “[t]his lack of conceptual clarity makes [patient-centered care] exceedingly difficult to operationalize and incorporate into research projects or clinical applications” (53).

Hobbs’s research also found that the way patient-centered care has been used in the literature “has narrowed the application of patient-centered care to clinical adaptation of the existing system” (54). She identifies a tendency for patient-centered care to be referenced superficially as a solution to specific system deficiencies in the absence of a robust formulation of patient-centered care. This focus is problematic as it directs attention to one aspect of patient-centered care without giving sufficient attention to its central concern: the patient and her relationship with health-care professionals.

Traditional models of care retain important influence in health care. Examples from nursing include Orem’s Self-Care Deficit Theory (Taylor 2006), Neuman’s Systems Model (Freese 2006), and Roy’s Adaptation Model (Phillips 2006). Various medical models of patient–physician relationship, or the clinical method, arising from different theoretical perspectives have informed the different generations of currently practicing physicians (Emanuel and Emanuel 1992).

As a result, an apparently underexamined, individualistic view of patient autonomy that isolates the patient as decision maker may linger among health professionals in practice and contribute to difficulties implementing patient-centered care. For example, in a study of elderly aboriginal women with cancer, Chris Sinding and Jennifer Wiernikowski (2009) conclude that a focus on patients that was individualistic and did not account for the relational and social components of their lives resulted in obscuring how social conditions and relationships shape available choices for patients.

Not all health professionals have the desire or skills to practice patient-centered care. Recent studies in nursing have found discrepancies between nurses’ beliefs about working collaboratively with families and their actual skills and abilities to do so (Bruce et al. 2002; Caty, Larocque, and Koren 2001). Other nursing studies point to concerns that in today’s chaotic care environments there is diminished ability to practice in a manner that fosters partnership, or

provides support and education to patients, consistent with expectations of patient-centered care (Bruce and Ritchie 1997).

Organizational structures can also contribute to challenges in implementing patient-centered care. Considerations such as time limitations and a lack of continuity of care are frequent obstacles (Coyne and Cowley 2007). Continuity of care may be diminished in models of staffing, such as team medicine, when health-care professionals responsible for a patient's care change on a frequent basis and when the patient's narrative and care are fragmented. Staffing and scheduling considerations may mean that health professionals involved in the care of a particular patient change frequently and staff has limited time to spend with individual patients. Diminished continuity of care makes it more difficult to understand the patient holistically and provide care that is patient-centered.

Shorter hospital stays also contribute to the challenge. Likewise, in settings of staff shortages, heavy caseloads, and mandatory overtime, health professionals may have less energy with which to engage the particular needs and concerns of individual patients (Peter and Liaschenko 2004). Learning about a patient's needs, goals, and values requires extended discussion between health-care professionals and patients (and potentially patients' families), and yet a health professional's time is often a scarce resource.

As we have described, there are important challenges to implementing patient-centered care in practice. Nevertheless, we believe that a patient-centered approach remains a substantially achievable ideal. While the theorizing that follows in this paper does not resolve all of the important challenges noted above, reconciling a theory of autonomy with patient-centered care may help health professionals with a professional commitment to a principle of respect for autonomy to align that commitment coherently with patient-centered care. Further, if convincing, our theorizing suggests that a key component of patient-centered care—that of relational autonomy—should be made explicit.

### **Autonomy theory–practice gap may linger**

Respect for patient autonomy is one of the most prominent ethical principles endorsed by health professions to guide today's health professionals in their therapeutic alliance with patients. Patient autonomy is typically conceived as an individual's right to make choices for herself that guide her life in a manner that reflects the purposes (preferences or values) that she determines to be meaningful for herself (Beauchamp and Childress 2009). In health care, respect for autonomy emphasizes in particular the patient's freedom of choice,

specifically over what happens to her body, her health-care information, and the integrity of her person. In many legal jurisdictions, a person's choice and control over such matters are likewise (or consequently) protected in law. As with other important values and rights, a principle of respect for autonomy is specified and weighted in relation to other ethical and practice considerations, in ongoing dynamic negotiations of therapeutic relationships and the goals of care.

Since its introduction to health care, theorizing about autonomy and its implications continues to expand and evolve. Note, for instance, that the articulation of the principle evolves through the first six editions of Tom Beauchamp and James Childress's landmark *Principles of Biomedical Ethics* (1979 to 2009). (Feminist contributions to this work are noted in the 6th edition and elaborated in the next section.) Early theoretical accounts of respect for patient autonomy in health care emphasized the individual's right to avoid unwanted interference from others (Beauchamp and Childress 1979; Emanuel and Emanuel 1992). This is not surprising given the use of the principle of autonomy in the twentieth century to dislodge and render unethical widespread practices of paternalism. Acknowledging and deferring to each patient's authority to choose or refuse medical interventions was critical for opposing unjustified practices of paternalism.

Although some early work in bioethics advances a notion of respect for patient autonomy that includes an active principle to promote patient autonomy (see, for example, Cassell 1976 and Jennings, Callahan, and Caplan 1988), recent discourse on respect for autonomy is more explicit about promoting, supporting and being responsive to patients' autonomous choices (Beauchamp and Childress 2009; Bergsma and Thomasma, 2000). (As will be described in the next section, a feminist formulation of relational autonomy will bring to the fore these other crucial aspects of an ethical understanding of respect for autonomy.)

In the early adjustment to include respect for autonomy in health-care ethics, many worried that uncertain or extreme interpretations or applications of a narrow or misconceived principle of respect for autonomy could promote contract-like relationships between patients and health professionals, isolate patients (or their families when patients are incapable) with decision-making responsibility, and block out discussion of and attention to other possible courses of action. Some questioned whether or to what extent respect for autonomy represented a moral trump for patients compelling physicians or other health professionals to act contrary to their professional judgment. Some felt that respect for autonomy implied that patients generally should be considered as rational, self-interested persons (Beauchamp and Childress 2009).

Such concerns seem to frustrate the potential of health professionals to form an effective therapeutic relationship with patients. The dominant discourse does not endorse such extreme interpretations of respect for autonomy that isolate patients in decision making (ibid.). However, dissatisfaction and flawed assumptions about what respect for autonomy requires may remain in clinical culture, and may influence the way that autonomy is understood by some clinicians. It also may be that despite advances in theories about autonomy and models of therapeutic relationships, there are many professionals who have not kept abreast of the evolution of ideas in this field.<sup>8</sup> In the absence of empirical studies that account for the absence of explicit reference and attention to autonomy in the literature about patient-centered care, we speculate but cannot confirm that such misconceived assumptions and implications about autonomy by health professionals in practice may be a contributing factor.

Advocates of patient-centered care would rightly distance themselves from a principle with these sorts of (misconceived) implications, and from health-care practices that (to a large degree) associate respect for patient autonomy with not interfering in patients' informed decision making. Patient-centered care is collaborative in nature. Relationship, sharing, and involvement of those close to the patient are embraced if the patient so wishes. Acknowledging that patients are complex, social beings interconnected and interdependent with others is a starting place for planning care. In short: a view of autonomy that isolates patients in their decision making would work against a patient-centered approach.

In the next section we present a feminist formulation of autonomy called *relational autonomy*. Rather than avoid association (or avoid acknowledging its association) with a principle of respect for autonomy, we will propose that patient-centered care explicitly identify respect for autonomy as an essential component. The feminist formulation of relational autonomy offers a conception of autonomy that is a better fit with patient-centered care and can serve this purpose. (Although not the intent of this article, the authors would argue further for a professional commitment to a principle of respect for relational autonomy, in part because relational autonomy is a better fit with patient-centered care.)

## **Relational autonomy described**

Evolution of current theory about autonomy now includes relational accounts of autonomy that have been substantially developed by feminist philosophers. The term *relational autonomy* refers to conceptions of autonomy grounded on the social nature of people's lives (Mackenzie and Stoljar 2000, 4). On these

views, people are integrally connected with a social environment marked by economics, politics, ethnicity, gender, culture, and so on. Their identity is formed and shaped by their social environment, as well as their experience of embodiment, interactions with others, and possibilities for a good life. Along with interconnection, the fact of interdependence pervades this relational understanding of the self, as people are only dependent and independent relative to the circumstances in which they find themselves (Ells 2001). This is the starting place whence conceptions of relational autonomy are formed.

In a relational approach, autonomy emerges *within* and *because* of relationships (Nedelsky 1989). An individual's identity and relationships with others are shaped by an embodied experience that influences how both the individual and others perceive and interpret different intersecting bodily characteristics (which include age, skin pigmentation, sex characteristics, different abilities and inabilities, etc.). Important skills and capacities are learned and practiced through interactions with others (e.g., patience, perseverance, trust, self-confidence, problem solving, effective communication). Social factors (e.g., culture, religion, the love and well-being of a spouse, a particular work ethic, value of charity) similarly are integral to one's sense of identity, one's interests, and what skills are learned. How relationships with others and the whole structure of society support, limit, or enable autonomy is taken into account explicitly (to the extent one is able) when the autonomy of specific individuals or groups (or autonomy tendencies within groups) is examined. Note that this feminist formulation of (relational) autonomy expands the scope of patient autonomy that health professionals must attend to. In addition to respecting a patient's capacity/right to make informed choices, health professionals must attend to the patient's sense of identity (that is, the *self* that is *self-governing*). The patient may identify with or within a vast web of relations. How far the patient's sense of self extends into the vast web of relations, or contracts into her discrete mind and body, will affect how and what she chooses in the process of self-governing.

Within a relational understanding of autonomy, self-identity and decisional capacities are dynamic in nature, changing with the meanings and structures of people's relationships and their world. Yet, they are not so fluid that the focus cannot remain on the individual. For, as Anne Donchin (2000) reminds us, "Any tenable conception of personal autonomy is bound to be subject-centered; but a social conception that is relational . . . will take into account the need for a network of personal relationships to develop and sustain competencies necessary to act as self-determining, responsible agents" (192).

Since autonomy is developed, exercised, and realized in a social context, it is important to create fair and supportive social contexts. Fair and supportive social contexts will establish relationships that allow individuals to develop and exercise their autonomy. Providing a social context that encourages individuals to participate in decisions, to ask questions and voice their feelings and concerns, as well as to take responsibility, allows individuals to develop their autonomy (Dodds 2000, 229). Conversely, when social contexts prevent individuals from making decisions, refuse to allow people to voice their feelings or concerns, or regard people as if they are unable to make decisions, people are denied opportunities to develop and exercise their autonomy.

In relational accounts of autonomy, having opportunities and developing skills for autonomy often go hand in hand.<sup>9</sup> Through having opportunities, individuals have various experiences that allow them to discover things about themselves and develop and practice skills and habits that support autonomy. Denying people opportunities to act autonomously not only reinforces the stereotype that they are incapable of being autonomous, but also inhibits their autonomy by failing to allow them to develop autonomy skills. However, we should not confuse not having opportunities to act autonomously with not being capable of autonomy. Further, while features of one's social context and one's own condition constrain what autonomy can be achieved, one can usually be empowered and enabled to express oneself within one's context. Importantly, because influential features of relationships must be accounted for, relational understandings of autonomy do not incline us to so easily brush aside the possibility of autonomy of others or the responsibility to help foster autonomy.

Promoting, supporting, and being responsive to patients' autonomy choices require the collaboration of others. They can involve such diverse actions as fostering autonomy skills (such as reasoning and communicating), helping to nurture new self-identities, providing emotional support, including and supporting family members, balancing power relations, responding to injustices, and creating environments that support autonomy. In short, in a decision situation, respect for patient autonomy with a relational understanding of autonomy can involve fostering conditions, in the patient and the patient's environment, that enable the patient to make choices to guide her life according to her values and sense of self.

While certain skills, personal attributes, and social conditions (such as good interpersonal skills, confidence, and a supportive family) may tend to facilitate the exercise of autonomy, and others (such as poor judgment, low self-esteem, and an oppressive family situation) may tend to hinder autonomy, it is

important to realize that there is no *one* formula for realizing autonomy and no *one* means to respect it.

If we assume that health professionals are justified in the value they ascribe to an ethical principle of respect for patient autonomy and that respect for autonomy involves promoting, supporting, and being responsive to patient's autonomy choices, as authors influential to the health professionals argue (for example, Beauchamp and Childress 2009; Bergsma and Thomasma 2000; Jennings, Callahan, and Caplan 1988; Cassell 1976), then health professionals may find in "relational autonomy" a very satisfying conception of autonomy that aligns with the ideal of patient-centered care. Indeed, we believe relational autonomy is a better fit for patient-centered care than a conception of autonomy that is not explicit about the relational context of autonomy.

### **Relational autonomy as an essential component of patient-centered care**

We propose that patient-centered care theory explicitly adopt a relational understanding of autonomy as an essential component. Relational autonomy is consistent with and responsive to the basic assumptions and commitments of a patient-centered approach. Adopting a relational understanding of autonomy would contribute to the understanding of patient choice and agency within patient-centered care without minimizing the complex nature of people and the value of collaborative decision making and collaborative approaches to care. We argue below that by explicitly adopting relational autonomy as an essential component, patient-centered care becomes more coherent, is strengthened, and could help practitioners to make better use of a principle of autonomy. Such a move would improve both patient-centered care and health-care professionals' understanding of patient autonomy.

#### **Consistent with assumptions and commitments of patient-centered care**

Recalling the definitive elements of patient-centered care presented above, we observe a consistency with assumptions and commitments in defining elements of relational autonomy. Note that patient-centered care puts the particular patient at the center of care planning. Through collaborative partnership, the patient and health professionals develop and act on a care plan that is individualized according to the particular patient's goals, preferences, and capabilities. Interest and attention are given to the whole patient—that is, the person

as situated in a complex social context—and what is meaningful and affects meaning in her life. So too does relational autonomy start with a commitment to the whole person as situated in a complex social context. In patient-centered care, others may factor into the meaning, interests, goals, preferences, and capabilities of the patient (as well as in partnering to plan and implement care). That role extends into relational autonomy where an individual's autonomy is shaped and enabled by relationships with others (as well as with the social environment, the experience of embodiment, and the possibilities for a good life).

In patient-centered care, health professionals seek a partnership with each patient that features shared control in consultations, decisions, and management of health issues, and a personalized relationship with each patient that acknowledges the conditions that shape what is meaningful for each patient. A similar engagement through personal relationship is needed when health professionals act on a principle of respect for patient (relational) autonomy. The approach toward the patient is individualized. Direct and indirect influences and contributions to patient autonomy are considered. These influences can include people close to the patient, health professionals, and social institutions (such as religious institutions of which the patient is a member, home-help services, legal system, government agencies), as well as the patient's characteristics, skills, social factors, sense of identity, and interests.

Current values in health care give credence to a broad understanding of patients' values and interests beyond merely physical and mental health. For instance, a patient may have specific social, cultural, and spiritual values and interests that affect or intersect a personal health matter. Attention to these values and interests is consistent with both patient-centered care and relational autonomy.

### **A more coherent theory of patient-centered care**

Some recent medical profession policy documents that discuss patient-centered care and collaborative care draw together patient-centered care with a conception of autonomy that is consistent with relational autonomy. For example, an American College of Physicians position paper entitled "Family Caregivers, Patients and Physicians: Ethical Guidelines to Optimize Relationships" asserts that "clinical encounters should be patient-centered, allowing for maximum appropriate patient autonomy and participation in decision-making" (Mitnick, Leffler, and Hood 2010, 256). This position paper, endorsed by ten other professional societies, goes on to describe and reference a variety of preferences patients may have for the involvement of others in decision making. Similarly,

the *Patient-Centered Care Improvement Guide* provides health professionals and organizations with numerous strategies that are in fact autonomy-enhancing; however, the term *autonomy* is used only once (to acknowledge that providing patients with choices about what and when they eat maintains patients' sense of autonomy) (Frampton et al. 2008, 100). By avoiding reference to a health professional's ethical commitment to respect for patient autonomy, the *Guide* seems to obscure the connection between a principle of respect for patient autonomy and patient-centered care. Within the health professions of many jurisdictions, there is an expectation that health professionals endorse and be guided by a principle of respect for patient autonomy, and that such a principle be integrated with prevailing models of care. By explicitly adopting a relational approach to autonomy as an essential component of patient-centered care, the theory of patient-centered care accomplishes this expectation of commitment with a conception of personal choice and agency that is coherent with the purpose, values, and objectives of its model.

### **Relational autonomy strengthens patient-centered care**

Patient-centered care is strengthened when health professionals explicitly integrate relational autonomy as an essential component. Doing so reinforces the active guiding role of the patient and supportive relationships. This helps to prevent lapses into mechanistic (or programmatic) approaches that ignore important features of particular people and the need to involve them significantly in decision making.<sup>10</sup> Further, this helps to avoid paternalistic approaches where the health professional's perceptions of the patient's good dominate decision making related to care while at the same time the health professional denies the patient control over the decision-making process.<sup>11</sup>

The active guiding role of the patient is given greater expression when following through on a professional commitment to respect a relational understanding of autonomy. While remaining centered on the particular patient's guiding role, health professionals can look to a wide range of options to respond respectfully to the patient's autonomy. This is so because patient autonomy is dynamically shaped by many factors in a social collaboration that extend beyond the therapeutic relationship. The act of collaborating with others to enable, support, and not impede a patient's autonomy also supports the goals of patient-centered care. Further, recognition that some relationships and involvement of others can impede a particular patient's autonomy, or otherwise be undesirable from a particular patient's perspective, reinforces the importance of assessing the value for the

patient of the patient's closest relations before involving them significantly in the patient's health care (a behavior strongly associated with respect for autonomy).

**Provides rationale to justify proactive steps to create conditions that are autonomy promoting**

By recognizing relational autonomy as an essential component of patient-centered care, health professionals can appeal to a principle of respect for (relational) autonomy to further justify proactive steps to create conditions that facilitate the patient's ability to guide care by promoting, sustaining, and not impeding their relational autonomy. This might include, for example, taking actions that build patients' confidence and understanding about managing their health issues within the particular features of their lives, helping patients/families to be able to describe complicated courses of illness or treatment to others, and minimizing the barriers or challenges for patients to access services and opportunities that support their health and well-being. Doing so facilitates outcomes (for health and possibly other domains) that are in accordance with patients' goals and preferences, and the goals of patient-centered care. Where organizational or institutional aspects of clinical settings can hinder this process, acting to address and change these contextual features is consistent with the promotion of autonomy.

**Potential to help counter existing challenges**

Adopting relational autonomy as an essential and explicit component of patient-centered care has the potential to help counter some of the challenges associated with putting patient-centered care into practice. This adoption alone does not complete the theoretical refinement needed for patient-centered care, or close completely the theory–practice gap. Nevertheless, the relational autonomy component can help to inform what could helpfully be among the next initiatives to pursue toward countering patient-centered care theory and practice challenges.

**Conceptual clarity**

To help counter operational challenges due to ambiguity in the definition and key components of patient-centered care (Hobbs 2009), our theorizing may help to clarify the relationship between autonomy and patient-centered care, as well as augment the set of patient-centered care's key components. As relational autonomy is explicitly integrated into discussions of patient-centered care, the literature of relational autonomy, including strategies for implementing respect for relational autonomy in health-care contexts,<sup>12</sup> can be drawn upon to guide

approaches for operationalizing patient-centered care. More generally, our proposal may foster renewed attention to the theoretical challenges of patient-centered care that consequently lead to difficulty in applying the theory in practice.

### **Targeted education**

The literature (Caly, Larocque, and Koren 2001; Bruce et al. 2002; Hobbs 2009; Lewin et al. 2009) already identifies or implies numerous education needs regarding the definition, key components, scope, and practice of patient-centered care. Some of these education needs can be addressed more effectively with an improved conceptual clarity that explicitly integrates relational autonomy. Yet, making use of relational autonomy in patient-centered care theory and practice requires educational initiatives that also pay specific attention to the concept and ethical principle of respect for patient autonomy. Health professionals and administrators need targeted education to provide them with more than superficial understandings of autonomy and patient-centered care. They need education about the nature of relational autonomy, what affects it, and how to respect it. This can help health professionals to overcome misunderstandings or lingering assumptions about conceptions of autonomy that are no longer endorsed in the dominant bioethics literature. Further, this may enable them to coherently integrate their professional commitment to respect patient autonomy with the partnership ideals of patient-centered care. As well, the active involvement of the patient, supportive relationships, and attention to context in planning and carrying out patient-centered care will be reinforced or clarified, with the additional ethical grounding of respect for (relational) autonomy.

Education about respecting relational autonomy may require enhanced communication and interpersonal skills development, including attentive and reflective listening, and speaking considerately and clearly. Skills such as these will enhance other aspects of patient-centered care practice (beyond promoting patient autonomy).

The provision of educational opportunities for patients and families should extend beyond basic aspects of their illness or recommended treatment. Patients may also need education to understand their relationships with health professionals and the health-care system, their role responsibilities, as well as the range and limits of their authority, so that genuine partnerships can be made with health professionals, with choice and agency enabled.

Respect for a relational conception of autonomy further validates the inclusion of family members or others whom patients want to include in

the patient–professional partnership, which thereby reduces patients’ isolation in decision making and promotes their ability and opportunity to guide the process of decision making and support. Yet patients do have limits to their authority in the partnership. For example, patients do not have authority to ration hospital resources, absolve health professionals of their legal obligations, or take actions that impose restriction or harm on others. While limits such as these to patient authority (and similar limits to health professionals’ authority) may not be discussed routinely with patients, health professionals should be prepared to educate patients and families about these matters and address any misunderstandings as to the scope or authority of parties involved in the therapeutic relationship and care.

### **Autonomy-promoting responsibilities and strategies in practice guidelines**

As indicated above, while there is no one means to respect patient autonomy, there are means that tend to facilitate the exercise of autonomy and there are factors associated with autonomous choice. Health professionals may find it helpful to include autonomy-promoting responsibilities and strategies in practice guidelines (or clinical methods) to help facilitate attention to these areas as part of routine patient-centered care. For example, assisting patients to maintain personal integrity helps them to achieve and preserve autonomy. Personal integrity involves not only making and acting on choices, but also maintaining personal values and relationships that matter, and achieving a balance among one’s important values. Knowing that being true to one’s values is important to one’s self-concept, health professionals can help patients to sustain their personal integrity by encouraging them to identify and be guided by the values that are most important to them, and to explicitly link recommendations or options to values or considerations that the patient indicates to be important. Sometimes promoting autonomy involves helping patients to adjust their self-concept and personal integrity in the face of illness or injury.<sup>13</sup> For example, in a study of patients with type 2 diabetes, Moser and colleagues (2008) examined nurses’ roles in helping patients to identify with their illness (i.e., to adjust and adapt their lives to the constraints of the diabetes) and the implications of doing so for the promotion of patient autonomy. They conclude that “recognizing identification as an element of autonomy enables nurses to adopt a more patient-oriented view of autonomy” (209).

A patient-centered psychosocial assessment is a key tool in patient-centered care to help understand and respond to each patient as a particular, interrelated

social being. A psychosocial assessment that probes only into behavior or social factors that might directly affect a body part or disease is insufficient for a patient-centered care approach where the health professional aims her focus on the particulars and interests of a whole person. A patient-centered psychosocial assessment starts with the patient and the patient's potential for involvement, striving to understand the contextual features of the patient's identity and experience, including key relationship ties with others, and the role the patient wishes herself and others to play. By beginning with a thorough psychosocial assessment, the health-care team gains insight into how the patient thinks, how the patient learns, and what some of the factors are that may either facilitate or hinder the development of a partnership in the therapeutic relationship. The assessment can also help patients and those close to them to look at their lives, identify their strengths and resources, and prepare to make changes that match who they are and their priorities. All of the above features of a patient-centered psychosocial assessment help to elicit information about the whole patient and foster a relationship of collaboration between patient and health professional. This approach also provides the groundwork for understanding and supporting a patient's relational autonomy. Furthermore, when conducting a psychosocial assessment, health professionals committed to respect for relational autonomy will be alert to factors that affect that patient's particular expression of autonomy. During this assessment, health professionals can begin to consider potential ways to promote and support the patient's autonomy. Further, health professionals can prepare for opportunities to address circumstances that hinder the patient's autonomy. By augmenting a patient-centered psychosocial assessment with specific attention to relational autonomy, the value of the assessment is enhanced, as is its potential to foster collaborative support in subsequent patient decision making.

Although some conditions such as having an empowering and supportive family are more likely to be associated with the development of autonomy than others, it is important to keep in mind that the conditions that bear on autonomy vary among people (Moser, van der Bruggen, and Widdershoven 2006). Health professionals will recall examples of patients who are motivated by important family relationships, forthcoming family milestones, or other defined goals to tackle the challenges of illness, injury, rehabilitation, or healing. Often people close to the patient are enablers who assist the patient in achieving, or striving to achieve, these goals. While some people manage fairly well without supportive relationships, if people close to a patient are unwilling to participate or support care planning, then they will be less willing and less able to accept the decisions that are

made, thereby potentially constraining these patients' ability to achieve their goals. Similarly, some people develop substantial autonomy skills despite disadvantaged circumstances, while others who seemed well positioned to become autonomous somehow seem less autonomous than we would expect. Mitnick, Leffler, and Hood (2010), writing on behalf of the American College of Physicians Ethics and Human Rights Committee, state that physicians "should develop care plans that are patient-specific and caregiver-specific and provide information, training and referrals to support those plans" (257). This guidance emphasizes that patient-centered care requires careful consideration of the relational dimensions of the patient's life. It should also be noted that families differ. Some families might be impediments to an individual exercising autonomy; hence, health professionals will need to examine with the patient what will be the potential contribution (positive or negative) of family involvement to the patient and her attempts to make and enact choices consistent with her values, goals, and sense of identity. With relational autonomy as an essential component of patient-centered care, these relational considerations are reinforced as integral to fostering and respecting patient autonomy.

### **Advocacy role**

Explicit attention to a relational autonomy within a patient-centered approach will motivate, and help guide, health professionals' advocacy efforts at several levels, as well as helping to situate health professionals' roles in relation to other actors. Because both achieving autonomy and taking a patient-centered approach to care require a collaborative effort, individual health professionals cannot alone have this responsibility. Health-care institutions, other social institutions, and other people (both known and unknown) can all significantly affect someone's autonomy and thus share in the responsibility for the autonomy of those they affect. While individual health professionals cannot control for all these factors, they have a role in advocating for education programs, health-care settings and systems, staffing practices, and policies that contribute to, and not hinder, the achievement of relational autonomy and patient-centered care. For example, policies and practices should help health-care providers create opportunities to involve patients and families in meaningful ways and support the patient in guiding her own care. Policies and practices that encourage patients to ask questions, discuss concerns, and explore the impact of an illness or injury can do this, as can policies and practices that support and facilitate informed choice, advance care planning, and the right to refuse treatment. Policies and practices should enable health professionals and institutions to have flexibility to adapt to

patient- or family-specific needs and goals. Policies and practices should not undermine patients' autonomy or sense of well-being by intimidating patients and families, invoking fear or anxiety, limiting reasonable choices, or causing undue emotional, financial, or social costs. Where institutional policies are justified by outdated conceptions of respect for autonomy or models of care that isolate patients in decision making, an explicit commitment to support each patient's relational autonomy can help to guide policies and practices toward current ideals. In other words, reinterpreting the ethical principle of respect for patient autonomy in light of what demonstrates respect for a patient's relational autonomy can help in revising outdated policies and practices to foster patient-centered care and professional commitment to ethical principles.

Quality assurance and quality improvement initiatives are needed to evaluate and guide local policies and practices to support patient-centered care. Health professionals can advocate for and help implement such activities in their practice settings. Including patients in administrative forums and on policy development committees provides opportunities for patient perspectives to influence policy development. In many jurisdictions, the accreditation standards for organizations that deliver health care will require that these kinds of policies and processes are in place. Where these are lacking or are less comprehensive, or when such policies need to be elaborated, advocacy based on the values and commitments of respect for relational autonomy and patient-centered care models can help more broadly.

While some underlying issues may appear difficult to address from within a clinical setting, there will likely be steps that can be taken (such as reallocation of responsibilities among staff) to mitigate their impact on patient-centered care, while advocating at a higher level for public policy change that will contribute to reshaping how these issues play out at the local level. An understanding of patient-centered care that includes attention to relational autonomy will motivate and guide such advocacy.

## **Conclusion**

The understanding that people are necessarily relational—that their very identity, and the possibility and reasons they have for taking action—arises from their relationships, and fosters our belief that there is a need in health care to ensure that therapeutic relationships are based on a relational understanding of people and on partnership. In addition to considering relationships and interconnections, a relational conception of autonomy draws attention to contextual features—such as the structures and policies of clinical settings—that support or

limit autonomy. Addressing conditions that hinder patient-centered care represents an important means of promoting autonomy, albeit in an indirect fashion.

Relational autonomy need not and does not dominate or drive the whole approach to care. However, relational autonomy provides a useful perspective to guide the realization of patient-centered care. At the same time, promoting relational autonomy supports critical examination of ways that patient-centered care is facilitated or constrained as a result of the structure and organization of clinical settings. Seeking to respond to a relational understanding of autonomy in patient care thus opens up a broad range of approaches for health professionals to promote the autonomy of patients. Since the theory and practice of patient-centered care appear to be improved by explicitly integrating relational autonomy understanding as an essential component, we believe clinicians seeking to practice patient-centered care should strive to respect relational autonomy.

The analysis we offer in this article is speculative in some respects in light of gaps in theoretical and empirical research. We hope that our analysis will motivate additional theoretical and empirical research so that more of the challenges of implementing patient-centered care can be overcome.

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### **Notes**

1. Other traditional models include, for example: Phillips 2006; Freese 2006; Taylor 2006.

2. For example, in Canada: McGill University School of Nursing; in the United States: University of Massachusetts Amherst School of Nursing, University of Arizona School of Nursing.

3. For example, in Canada: Faculties of Medicine at McGill University and University of Calgary; in the UK: School of Clinical Medicine at University of Cambridge; in the United States: Dartmouth Medical School, University of Pittsburgh School of Medicine.

4. For example, in Canada: Capital District Health Authority in Nova Scotia; in the United States: The University of Maryland Medical Center, Duke University Medical Center.

5. Canadian Medical Association 2010; Institute of Medicine 2001; Mitnick, Leffler, and Hood 2010.

6. Quill and Brody (1996) call their model an “enhanced autonomy model” (765), which they describe as “relationship-centered” (765) to emphasize inclusion of patient, physicians, family, and others in decision making. They distinguish it from models that force independence on the patient, which they associate with patient-centered approaches (but which we would describe as patient-focused approaches). See also Pollock 1993; Law, Baptiste, and Mills 1995.

7. This ambiguity of definition, and with it a corresponding difficulty to measure, is also evident in a Cochrane review (Lewin et al. 2009).

8. The authors cannot corroborate this idea beyond our anecdotal experience listening to and working with clinicians considering the implications of respect for autonomy in a number of clinical practice locations. Yet, medical education concerns about the hidden curriculum, the rise of attention to communication skills, and professionalism may imply that autonomy is perceived problematically in clinical practice.

9. See, for example, Freedman 2003; Mackenzie and Stoljar 2000; Sherwin 1998; Meyers 1989; Bergsma and Thomasma 2000.

10. Here we do not mean to undercut the value of standard practice guidelines for managing the care of patients with hypertension, breast cancer, sleep apnea, and so on. Care-plan trends will often develop among patients with similar health challenges, but in a patient-centered approach the health professionals must individualize and broaden the care plan in partnership with the patient, being responsive to the particular values, needs, preferences, capacities, and context of each patient.

11. See Sandman and Munthe 2010 for a discussion that addresses continued concern for paternalism in clinical practice, and conceptions of paternalism that vary in relation to conceptions of autonomy and models of therapeutic relationships.

12. See, for example, Kenny and Ells 2002; Ells 2001; Donchin 2000; Sherwin 1998; Law, Baptiste, and Mills 1995; Pollock 1993.

13. Losses may need to be grieved. Priorities and life plans may need to be altered. Priorities may remain the same but how they are accomplished may need to change.

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