Limited autonomy and partnership: professional relationships in health care

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Author's abstract

Principles of autonomy and self-determination have been upheld as vital to modern-day medical and ethical practice. However, the complexities of current health care and changes in the expectation of some patients and their families justify a review of such concepts. Their limitations and relativities may suggest that other descriptions of partnership and negotiated goal-setting, while based on respect for autonomy, reflect more modern and ideal multi-disciplinary practices.

 Discussion should extend beyond the 'classic' participants of patient and doctor to a more realistic picture where other health carers are included. It is therefore apposite that other professional relationships are considered as they affect areas of doctors' and patients' responsibilities. Such partnership between members of the team may not be without problems and conflict, but the principle of negotiated agreements could result in more long-term harmony, and greater patient welfare.

Introduction

Current principles accepted by a majority of medical practitioners and ethicists reflect a respect for individual autonomy. Authoritative accounts of patients' autonomy define this as an 'acknowledgement of their right to make their own deliberated decisions within the context of their own life plan and preferences, so far as this does not harm others' (1). Where possible patients should therefore be given adequate information and the opportunity to participate in decisions and discussions to do with their care. Yet at times this may not be possible. As Benson (2) has cogently argued, autonomy is a relative concept, people being autonomous to different degrees, depending on their situation and those who are ill are often assumed to have automatically reduced powers of autonomy (3), necessitating action by others when this is considered essential for their welfare. Such paternalism, based on the principle of beneficence, is thought to be justified when experts are confident they know what is best for the patient (who would consent

Key words

if he/she were able) and what they propose would harm no one else.

Despite the views of those authors who maintain that paternalism has the strengths of objective judgement (4) and concern for the patients' well-being (5) it is generally seen as a necessity only when autonomy is unavoidably limited. Even so, O'Neil (5) maintains that some patients want relief from decision-making and the burden of autonomy.

It may be that the setting, type of discussion and care provided determine whether patients' autonomy can be fully respected. For instance in primary care (where the majority of patients are seen) most individuals seek help and treatment for minor, short-lived problems or alternatively for chronic illness, sometimes requiring hospitalisation. In the latter case they are frequently knowledgeable about their condition and treatment and although they may suffer grave symptoms resulting in tiredness and dysphoria, this may not reduce their capacity or their wish for full participation in planning.

Respect for autonomy is preserved and highlighted by the 'fiduciary principle' or health care partnership, described by Dyer and Bloch (6) as applied to the mental health field. This involves joint decision-making and seems to capture the desirable therapeutic relationship of trust, equality and negotiation, not just advice-taking. It also accepts patients' views as valid and important, obviates a paternalistic stance towards patients and helps to prepare them for further decision-making opportunities. These authors state: 'The principle of partnership represents the ethical ideal even more fundamentally than the paternalism of which the medical profession is often accused, or the more impersonal respect for autonomy which is commonly substituted for it'. Yet the realities of a partnership should maximise joint decision-making and goal-setting and thereby respect the patient's autonomy. To me it seems that these concepts of autonomy and the fiduciary principle are related and not distinct.

Relevance of the notion of partnership extends beyond the psychiatric milieu to much general medical and health care. Given that the majority of clients and patients are capable of understanding the rationale for treatments and are expected to cope with the

consequence of many health problems, concepts of partnership are useful. Medical practice has changed, no longer relying on assumed patient compliance and beneficent paternalism. Trust of the practitioner now has to be earned in most Westernised, industrialised, educated, critical and litigious societies (7). Other health care workers are also involved in making treatment plans, monitoring the patient's progress and referring back to the doctor.

Ideas of partnership in care have been developing for many reasons. For instance, over two decades researchers have demonstrated that control over aversive events reduces stress, is preferred by subjects (patients and others) and has beneficial effects such as the reduction of anxiety and distressing complications (8). Information which encourages behavioural or cognitive ways of coping has been found particularly useful for patients about to undergo painful diagnostic tests or surgery (9,10). Full consultation and informed consent is clearly essential for feelings of control.

Consumerism, or the right to self-determination and choices for the client, has become a desirable phenomenon in this country and in particular in the health service. Seen as a reaction to the strength and social control of the medical profession (11), alternative treatments, self-help groups and community health councils have developed.

For those with chronic illness a sense of mastery and full adjustment to optimum functioning is obviously desirable. Teaching sessions by staff for those with such conditions as diabetes, hypertension and coronary artery disease have been commonplace for some time. Evaluation of such interventions in experimental studies (12) demonstrated the benefits of increased knowledge and sometimes better levels of adherence to medical advice. However, over the last decade researchers have acknowledged that 'coping with illness' is a complex process, facilitated by emotional support, family involvement and a problem-oriented approach in 'teaching' sessions (13). They found that more positive outcomes were associated with client-led sessions with a staff member or ex-patient acting as a counsellor, listening and encouraging problem identification and resolution. Rather than the active information-giving or teaching role clients and staff alike needed to adjust to a more equal and less structured process. These studies, therefore, by adopting an approach comparable with the fiduciary principle, demonstrated a favourable therapeutic outcome. To that end staff should accept on clinical and ethical grounds that partnership with patients and each other is beneficial. Individual patients' wishes to participate must of course be carefully assessed, and respected, avoiding imposition of this sort of strategy against their will.

Change in style from the previously acceptable professional leadership to client participation and choice will require an alteration in predominant philosophy and practice. Health workers will need to provide sufficient information, rationales for treatments and to negotiate specific goals with those they care for. Mutual commitment to treatment goals or contracts are recommended by Dyer and Bloch (6) as well tried in psychiatry but relevant to other settings.

Implications for other health care workers

Doctors, nurses and others need to recognise the potential of 'partnership' in every-day work with patients, and within their own relationships. By studying specialties where this has developed, for instance in terminal or palliative care, staff will realise that medical or clinical concerns tend to compete with other pressing personal and social priorities. In such non-acute settings patient and family autonomy is preserved and the professional voice is one amongst many in the decision-making process where the patient is the central figure (14).

It must be realised that professional knowledge and advice may not now be seen as the most important determinant of decisions – although where consultation with a member of the health care team has occurred it is often requested and probably valued. In an open partnership expression of opinions and honesty are important for mutual trust. Staff must learn to accept it when their advice is not considered appropriate or correct for an individual and work for a compromise and a useful plan. This is in contrast to Sider's (15) point that by refusing advice the individual patient is risking rightful disapproval from the doctor (or other). The client must also enter into the partnership explicitly by agreeing to discuss his preferences openly. Passivity and unquestioning agreement with subsequent non-adherence to treatment plans is therefore contrary to the principle of partnership. Those people who have been socialised to rely on the 'wisdom' of others and to accept with gratitude and without challenge will obviously need to be helped to see the benefits of this approach and to be given the choice to participate in this way. As Brooking's study (16) in general hospital wards demonstrated, a majority of patients adopt an acquiescent role which is still expected and preferred by many nurses.

Thus, the supremacy of professional knowledge inherent in the principle of beneficent paternalism is totally alien to the fiduciary principle. Some may feel this is de-professionalising or that it undervalues the contribution of members of the health professions. They may feel that just at the time when health carers, such as nurses and physiotherapists, are creating an emergent body of knowledge from their research efforts and taking on particular areas of responsibility, professionalism is being rejected as paternalistic, elitist and non-progressive. In reality the opposite is happening and much research shows how nurses and others can help people more, as well as providing a firmer base for their practice (17). As counsellors have been trained to withhold advice unless it is requested to facilitate a client's adjustment, rather than organising services or taking over, so the good therapist will help

people to cope so they and their families are less dependent on staff in the future. In many ways this is akin to principles of rehabilitation care, in general, where staff never intervene when an individual may regain independence through rehearsal and well-planned provision of aids and support.

Thus there are implications in adopting a fiduciary relationship not only for patients and their relatives but also for health workers apart from doctors. Imposition of nursing treatments or plans of care for instance would be contra-indicated where the medical team were fostering client independence and choice. Ethical principles therefore underpin this approach to care, whereby each member of the team should act consistently and be fully consulted. Many partnerships can be formed between the client and various health workers and between those on the staff. This style of negotiated care-planning and open decision-making challenges all notions of paternalism or unilateral leadership by the doctor. It will affect the delivery of care, type of treatments agreed and communications between health care workers.

Dynamics within a multi-disciplinary team will obviously be affected by this underlying philosophy. Most teams, in practice, are doctor-led because of the pervading medical model used to train 'para-medical' staff. However, this is clearly incompatible with the fiduciary principle. It is surely illogical to treat one's patients as equal and encourage staff to do likewise while not giving these staff members sufficient opportunities to develop their own strengths and opinions. Colleagues need to demonstrate their belief in partnership and equality to each other in order to obtain relevant care and gain trust within the team in the same way that clients learn to trust them. Indeed, this is already demonstrated in many multi-disciplinary teams in the non-acute setting. The hospice movement, some primary health practices and geriatric care settings provide the best examples of multiple input and partnership. Here as elsewhere patients' problems pertain to social and economic situations, to practical issues of how to move about or buy the groceries or even to isolation. Symptoms may be attended to by one or other of the team, depending on the cause. Each member has his or her special contribution to make to the welfare and well-being of those being cared for.

Health care workers need to understand that equal recognition for their contribution implies full accountability. Independence of practice or autonomy carries the full weight of providing optimum service to benefit those who ask for this. Peer review should be undertaken to ensure this is provided, peers acting as equal partners. For, in order for nurses and others to achieve some independence of practice, their knowledge and skill must be established, standards must be clearly identified and achievable and others must recognise their areas of independence and accept this care is necessary. Chronicity, old age and increasing prevalence of self-inflicted diseases surely

make complementary areas of practice of equal value to medicine. Thus nurses need to provide psychological care as preventative strategies and for alleviating distress of patients and relatives and they need to work through practical problems which have arisen as a consequence of illness and provide symptom relief and physical comfort. There will always be a measure of role overlap between medical and other health workers, the degree being influenced by the nature of problems and the clinical setting. However, it is necessary to define areas of expertise so that the public receive skilled attention, economically and efficiently. Such expertise must be built on research evidence on what effects the best outcome.

This process is exemplified by specialist nurses who have developed their own expertise to meet clients' needs and have then evaluated their contribution. The evidence tends to be positive, as in the case of the nurse practitioner acting as an independent agent in a primary care setting. Stilwell's (18) findings show that individuals seek access to the nurse practitioner predominantly for health education, child-rearing problems, advice on caring for an elderly relative, counselling for 'worries' and advice on managing practical problems related to chronic illness. General practitioners are increasingly realising that their own expertise can be employed more efficiently in areas of medical diagnosis and treatment and that they can refer many patients and families with more general health-related problems to the nurse practitioner.

Autonomy or self-determination with the associated burden of responsibility and negotiated partnership seem to be desirable for many patients and for their health care workers. So professionalism needs to be seen as a clearly contained and limited concept built on expertise and usefulness. Preservation of autonomy for all those involved in the multi-disciplinary team is promoted by following the fiduciary principle. As yet this is not fully exploited in all areas of practice, patients and their families are frequently ill-informed and health care workers have not been granted their own personal and professional autonomy despite the fact that many clearly deserve this.

There is a full philosophical literature on the principle and benefits of patient autonomy (19) and also on the extent to which they still suffer from inadequate information and choice (20). Much less has been published (in the learned journals) on the abnegation of professional autonomy or the rights of those working with doctors as members of the health care team. Yet there is evidence that nurses, in particular, are being demoralised and de-skilled (21) within the health service, erosion of expertise and a lack of respect for their abilities and contribution leading to high attrition rates. In other words, nurses are frequently not treated as equals or as partners, particularly in the acute hospital setting. Those in positions of control, among them a few nurse managers, are criticised by nurses for not treating them with politeness or respect, for not listening to them and

for failing to give them a reasonable workload (21). Other professional rights and duties which might be expected include the freedom: to determine their own priorities; to ask for resources they require; to refuse requests without feeling guilty; to make mistakes and be responsible for them; to give and receive information as a professional; to help in the best interest of the patient and his family; to question others who give care, and to be a patient advocate or help patients themselves to be self-advocates (22).

In a truly team-oriented, multi-professional partnership all these rights would be accorded to each member, including the patient and family. No one individual should be seen as less significant than another, even though they are employees or legally accountable to others. The consequences of this arrangement imply cross-referrals, requests from one another, open communication and review, with patients being full members of this process. Benefits include full commitment, clear self-accountability and ethical treatment for all. So what problems might occur, during the period of change to this system?

Just as the patient may be unused to being assertive and critical, nurses, doctors, physiotherapists, social workers and others may find this stressful. Despite the complaints well versed by nurses that they are 'put upon' and act as everybody's hand-maiden rather than being in a position to give priority to patient care, they (we) often seem unable to become more assertive and challenging (22). At present of course, if nurses were to refuse certain requests there would be no one else readily available to run the errands or clear up! Either those who need the errands (nurses, patients, doctors) must run them or those who make the mess (nurses, patients, doctors) must clear it up, and frequently they do, but seemingly not frequently enough.

Although many members of staff respect and care for those they work with, others are less considerate, valuing the protection of closed communication or lack of communication and a team of staff or patients to do their bidding. Certainly arguments about fairness will need to be combined with demonstrations of therapeutic efficiency in order to compel a change in these people's behaviour. However, examples of the fellowship and mutual support created by partnership in care may encourage some to become more consumer and staff-oriented.

Problems do occur when staff members are unable to acknowledge their own contribution or that of another or unable openly to disagree with each other and negotiate a solution. Enduring paternalism or leadership by one member of the team, with unnegotiated delegation denies the rights of equal partnership. This type of style tends to be passed on to others, as Revans reported (23). In this research it was found that when authoritarian rather than democratic decision-making occurred on general wards, staff who were not presented with alternate models adopted those they currently observed. Staff wastage and sickness were high and patients' care reflected this. On the other hand when open government and agreement prevailed, patients cared for were more satisfied and fared better and were more likely to receive relevant care and be treated with courtesy and respect by staff, who reported a higher level of morale.

Negotiating skills are not traditionally taught to those who receive or provide health care, yet open discussion of preferences and priorities is fundamental to most partnerships. Realistic compromise with an individual to agree a plan of care is advised by a majority of therapists aiming to change complex behaviour. As Dyer and Bloch (6) explain, participants enter a contract through bargaining and mutual agreement. If either party is unable to do this, the partnership is unlikely to work. Imposition of the wishes of one person, be it patient, relative, doctor or nurse, against those of another is likely to meet dissatisfaction, resentment and non-compliance, none of which foster harmony or health care. This also means that the wishes of those who do not want actively to participate should be respected. It is obviously the opportunity and openness of communications which should be maintained.

Reasoned and clear priorities must be identified by members of the team in order for contracts to be made and partnerships kept. This extends beyond simple issues like good time-keeping to careful planning and communications. Regular opportunities for revision of arrangements should be made. Most health centres, specialist teams and psychiatric services hold such meetings but this is rarely seen in the general hospital setting, where it is arguably most needed at present. Ward rounds could be renamed meetings but they are often not conducive to open discussion and rarely include all members of the 'team'. Degrees of partnership in this setting rely on the openness or facilitation by the consultant or the assertiveness of other members. Ward sisters, for instance, rarely call for a meeting to discuss policy and strategy.

One other problem which may need to be considered is that of 'general management' (24). Although accountability is applauded in this 'new' philosophy, this tends to be seen as economic accountability with quality of performance being set against other priorities for spending. Control of professional performance by non-professionals could be viewed with concern unless the manager becomes involved in the partnership and also negotiates with team members. Agreement to this may be forthcoming but trust is also essential!

Progress towards partnership in health care will require more 'give and take' in order to motivate, satisfy and fully exploit potential in others. Medical staff and other managers might have to give more time and effort to listening and even encouraging demands. Greater colleagueship, partnership and trust should result, in return staff would be expected to be confident in expressing opinions and wishes. All staff would also need to give of their best efforts for the benefits of those who require this attention, feeling

fully accountable for all that they do. Without a certain degree of autonomy within this inter-dependent team partnership cannot evolve.

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