

Empowering patient autonomy in dialysis patients via a doctor-patient relationship model

Joaquim Pinheiro

Instituto de Bioética, Universidade Católica Portuguesa. Oporto, Portugal.

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Patients with chronic kidney disease on dialysis live with a persistent burden of disability¹. They deal with multiple stressors as a consequence of their illness and treatment², making improved dialysis care a must. But what is the optimal approach to these patients?³

Performance can be evaluated as patient outcomes, which can be objective (biological data) or subjective (patient satisfaction indices). The latter are correlated with the physician-patient relationship. Less frequent contact with nephrologists was correlated with nonadherence, lower Kt/V and lower haematocrit⁴. Biochemical and other biological targets must be achieved, but patients want more from their physicians⁵. The patient-physician relationship consists not only of frequency but quality or length of contact. A positive correlation between patient satisfaction with their nephrologist and adherence and some biological data has been found⁶. This relationship includes other medical personnel and staff, and every single task, directly or indirectly related to the patient, which goes beyond patient care. But what is the best patient approach, the best physician-patient relationship model?

Disease often makes people more passive than they would be when healthy. With disease they easily let others take care of them and make decisions

for them. The patient is no longer able to drive his/her life due to the incapacity and the consequent limitation caused by the disease. In addition, the person is limited by the treatment, the recommended prescriptions, and restrictions and conditions, which include behaviour, schedules, rhythms, displacements, tests and medications. Emotional dependence is mentioned by dialysis patients related to the machines and the staff⁷. The loss of self-control and the feeling of dependence make patients feel unsafe and anxious⁸. When people become ill they lose autonomy. Self-control improves patient autonomy, and this improves the patient's sense of him/herself as a fully rounded human being and a person⁹.

Therapeutic goals are not only to recover physical and biological health, but to recover self-control and a better quality of life and autonomy⁵. In other words, autonomy empowerment is also a therapeutic goal¹⁰.

This is important for the patient but also for physicians, as on average nephrologists spend 43.9% of their time caring for haemo- and peritoneal dialysis patients¹¹. How can physicians enhance patient autonomy? The physician-patient relationship is decisive for the patient with a chronic disease¹².

The conventional model of doctor-patient relationship is represented by the authoritarian professional (physician and other staff members) who determines the rule, and the obedient patient who

obeys the orders received. Doctors' authority rules illness and treatment¹³. Authority is heteronomy, and therefore reduces the chance for autonomy. This is the doctor-centred approach¹⁴.

In alternative, the patient-centred, biopsychosocial, integrated approach promotes patient autonomy and reduces its loss¹⁵. The patient-centred approach is the one preferred. The patient-centred approach is positively associated with patient satisfaction indices, adherence and better health care outcomes.

In chronic kidney disease patients, its implementation corresponds to a programme that includes a set of procedures to define the real way the different professional sectors should take care of patients. What patients want is an integrated, whole-person approach, not a fragmented one⁵.

This global approach can be divided into five items: respect for patients' values, preferences and expectations; global and continuous communication about the illness and the treatment; patient, family and friends' involvement in patient care, increasing self-care and autonomy; emotional support, fear and distress relief, in order to maximise mental and physical comfort; specific and global health care coordination as well as social support¹⁶. The systematic application of these procedures seeks to optimise dialysis care.

In terms of respect for patients' values, preferences and expectations, the therapeutic or diagnostic proposals must be based on preferences and personal outcomes¹⁴. Patient choice between conservative treatment and dialysis and between dialysis modalities must be promoted. Patient choice must be empowered. The scheduling of tests and other evaluations must be in line with patients' interests and possibilities. Patients follow medical advice better when it reflects the patient's own interest and concerns. Patients strongly prefer a nonjudgmental medical approach⁵.

Global and continuous communication about the illness and the treatment outcomes must always be shared with the patient. Dialysis strategy and medications must be negotiated with the patient, with prior information as to the justification, goals, benefits and possible side effects. The different functional and biological tests and the dialysis session data have to be explained to the patient.

Patients feel vulnerable and confused, and in consequence a multidisciplinary education programme must be implemented to enrich the patient's knowledge. Ongoing predialysis educational programmes should be improved^{17,18}.

Even when biological and functional targets are achieved, a residual syndrome remains¹⁹. Therefore, health care improvement needs to go beyond the patient's disease. The goal is to increase self-care and self-management. Keeping the family informed can enhance support for routine activities and for every life event¹⁴.

Psychological, social, quality of life (QOL), occupational, physical activity and adherence evaluation and identification of concerns is a way to provide emotional support, fear and distress relief, and to promote reappraisal as a coping strategy to maximize global comfort.

Specific and global health care as well as social support coordination will promote care enhancement and patient satisfaction. This includes dialysis issues, nonrenal acute episodes and comorbidities.⁵ In an American study in dialysis clinics, 97.9% of physicians manage nondialysis problems, including primary and preventive care²⁰. Continuity with the same physician is a key factor for patient satisfaction.

■ CONCLUSION

As dialysis patients are highly dependent, autonomy empowerment must rule doctor-patient relationships, as a biopsychosocial, integral, patient-centred approach.

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Correspondence to:

Dr Joaquim Pinheiro
 R. da Granja, 33 Águas Santas
 4425-094 Maia, Portugal
 E-mail: joaquimpinheiro@netcabo.pt