Differences in Rational and Relational Autonomy during End-of-Life Care

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Introduction

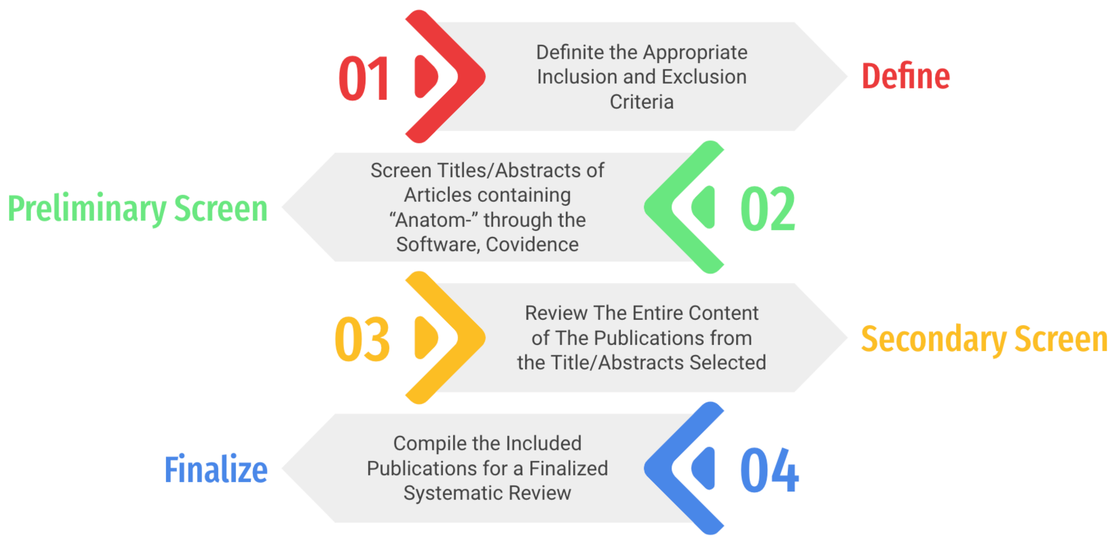
There are several concepts that contend with one another in relation to a patient's rights regarding his or her treatment. Specifically, the four principles that predominate the theoretical framework for bioethics are autonomy, nonmaleficence, beneficence, and justice [1]. One of these principles, autonomy, is a patient's right to make decisions regarding his or her medical care and choices. Throughout the years, ethicists and clinicians have debated the benefits and disadvantages of the roles of individualism and familiamism during the process of making medical decisions [2]. These discussions led to the rise of two concepts known as rational and relational autonomy. Rational autonomy is defined as an individual patient making decisions based on their own beliefs, attitudes, and customs. Rational autonomy is often associated with what individuals often perceive as the classical definition of autonomy. Relational autonomy, however, focuses on a patient's desire for the perspectives of the patient's family, spouse, or other trusted individuals when making choices about one's care and treatments. Rational and relational autonomy are particularly prevalent when making decisions regarding end-of-life care. This examination is important for achieving the goal of assisting physicians and other healthcare workers in understanding, recognizing, and inferring upon if and when a a patient may prefer to address shared-decision making from a frame focusing on making choices alone or with the involvement of loved ones.

Aims and Objectives

- Promote finesse, respect, and compassion within shared-decision making between a patient and physician solely or a patient, physician, and individuals a patient wishes to involve.
- Discover how rational and relational meanings of autonomy are more or less connected in a patient's medical decision making regarding end-of-life care.

Methods

The project utilized the software, Covidence. This program allows users to organize articles for systematic review management, for which we used search parameters to screen through 10,614 articles that were found pertaining to autonomy. During the selection process in which abstracts were chosen based on specific inclusion and exclusion criteria (inclusion: uses the term "autonomy" in the title or abstract, focuses on patients, focused to some substantial degree on clinical care, normative claims made in the title or abstract, focuses on autonomy. Exclusion: does not use the term "autonomy" in the title or abstract, not focused on patients, not focused in any substantial way on clinical care, normative claims not made in the title or abstract, not focused on autonomy). A full-text review was then utilized for 126 articles. After this, a total of 81 manuscripts were chosen to be extracted for the final systematic review. Lastly, 12 articles were studied that specifically related to rational and relative autonomy, and six of those pertained to end-of-life care.



Results

Rational autonomy's role in end-of-life decision making tended to predominate when patients had a healthier state of mind [3]. Patients tended to utilize rational autonomy when decisions were more concrete and there is less ambiguity with treatment outcomes. Benefits for rational autonomy were that patients felt as though their personal values were being expressed and that their medical affairs were more private [4]. However, the concept of rational autonomy begins to become less reliant when a patient's end-of-life course is caused by a more physically, emotionally, or mentally demanding disease [5]. When there is a higher degree of uncertainty with the next step in management or a higher sense acuity of care, relational autonomy tends to be more favored than rational autonomy because a patient wants input form his or her family and/or friends [6]. Because one has his or her friends or family to help make medical decisions when utilizing relational autonomy, patients felt a decreases sense of loneliness, cultural values are addressed more fully, and a person can more clearly see the advantages and disadvantages of potential decisions and changes in his or her rationality based on support and advice from family and/or friends. However, there is a degree of disadvantage to relational autonomy due to a risk of potential patient abuses, coercion, and interventions that are not desired by the patients from friends and/or family.

Conclusions

Health care providers should be cognizant, should infer, and should assess how their patients want to make medical decisions. While some patients may want their family and/or friends involved with their medical decisions, there may be other patients that want a more independent approach towards their medical management. A higher sense of grace in the conversations between a clinician and patient may occur when making end-of-life decisions if a health care provider is aware of the differences between rational and relational autonomy and how to apply them to interpersonal interactions. Prioritizing these concepts will allow patients to feel more liberty and self-determination when facing difficult medical decisions towards the end of their lives.

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