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Accommodating autonomous; chronic patients' meaning of autonomy in clinical setting in Iranian in-patients: A grounded theory study

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ABSTRACT

The aim of this study was to explore autonomy in chronic patients in clinical settings of Iran. The present study was performed in 2014 through a qualitative approach and the Grounded Theory with the participation of 34 persons (23 patients, 9 nurses, 2 physicians) who were recruited through purposeful and theoretical sampling. The data were collected through comprehensive interviews and observation of the hospitals in Tabriz and Hamadan, Iran. The findings were analyzed with the MAXQDA10 using the analysis method of Corbin and Strauss (2008). Data analysis resulted in 5 main categories and one central category. The five main categories were exposure to paternalism, attempts to express their opinions, attempts to prove their ability, attempts to shared decision-making and attempts to self-determination. The central category was accommodating autonomous, which demonstrates the perception of chronic patients of their autonomy during hospitalization. Generally, though changes in patients' health and lives can create serious threats to their autonomy, patients comply with condition. By considering this moral concept, medical teams can help patients enhance their autonomy during relationship.

Key words: Personal autonomy, chronic disease, Inpatients, Hospital, Iran, Grounded theory

INTRODUCTION

Maintenance of autonomy in chronic patients is challenged by sweeping changes resulting from multiple functional destructions (body, mind, and spirit) in chronic physical diseases and negative image of the community. These people do not have the energy to make good decisions or cannot make decisions without the cooperation of others [1]. The negative effects of exposure to uncontrollable events: either neglecting people's right to information or forgetting to ask for consent (to daily activities or medical procedures), to more critical interactions, such as privacy invasion, disturbing patients while they are asleep. All of these attitudes or behaviors have negative consequences and happen without any patient intervention, leading to frustration and increasing patient's dependence. [2].

One of the complaints of chronic patients is that doctors do not listen to their talk, or do not care and do not agree with what they say. This is during the time chronic patients are dependent on doctors for the long-terms; this results in patients' confusion [1]. Identity and self-esteem in persons obliged to be dependent due to illness is damaged [3].

Conversely, the support received from autonomy is positively associated with trust, satisfaction, patient's mental health [4], accelerated recovery and decreased hospital stay, satisfaction from hospital service, and improvement of service quality [5].

Patient autonomy is one of the principles of medical ethics, which means the ability to make judgment-based decisions [6, 7]. Autonomy is a culture and context-related phenomenon [7] that has been defined differently in various contexts: paternalistic model, self-governance, self-care, relational autonomy, actual autonomy, shared decision-making, communicative ethics, critical reflection, self-creation [8, 9]. In the Iranian traditional medicine literature, autonomy means the presence of the patient through supervision or mastering on work [10]. Autonomy is a driving force of human soul, just same as will, freedom, and choice [11]. Like many other countries, the health care system in Iran has been affected by paternalism. Paternalism in the health system means that decisions are made by healthcare providers rather than patients and regardless of their own views [12, 13].

In Iran studies suggests most patient not being aware of their rights and nonconformity ideally patient's right [5]. In response to questionnaire in a study in Iranian patients believed that their autonomy was not respected [14]. The majority of patients are not aware of before signing the consent of its content, however, is often accept treatment [5, 15].

Moreover, a disagreement exists about the meaning of this ethical concept according to empirical studies [6]. In Iran, Darvishpoor Kakhki *et al.* (2008) was conducted a phenomenological study to understand the concept of autonomy from the viewpoint of elderly people. Older people described autonomy with the concepts of being a self-directo [16]. Van Kelffen *et al.* (2004) clarify how the concept of patient autonomy can be applied to patients who refuse a recommended oncological treatment with qualitative method in the Netherlands. Patients mean autonomy making decisions and defining life choices [17]. Moser *et al.* (2006) studied the concept of autonomy in type 2 diabetic patients with grounded theory research method in the Netherlands. Participants of this study described autonomy with the concepts of identification, self-control, ideal paternalism, authority, participatory decision-making, planned monitoring, and responsive relationship [8]. Participants in a study by Levoie *et al.* (2011) in the Canada based on a phenomenological approach, had experienced autonomy as affirmation of identity as a human being, ability to act by oneself, generation of positive impacts on well-being, experience of difficult and sometimes painful feelings, altered relationships and adoption of different attitudes with regard to the future [3].

But how the concept of autonomy is perceived by chronic patients admitted to hospitals in Iran? Since identification of ethical dilemmas of performance, identification of resolving methods of these issues, and evaluation of the outcomes of these solutions is possible only by dealing with them [8], Furthermore, despite the importance of the patients' autonomy and the emphasis on the patient right, native studies that specifically examined to explore the concept of autonomy in hospitalized patients limited and this concept is not clear in Iran [14], then the authors sought to investigate the meaning of maintaining autonomy in hospitalized chronic patients through a qualitative research.

MATERIALS AND METHODS

Aiming at explaining the meaning of autonomy in chronic patients in clinical settings, this study was conducted through a qualitative approach and the method of Corbin and Strauss grounded theory (2008) [18]. Autonomy forms in social context and in relation to others [9]. Grounded theory is a qualitative research method which explores and explains social processes appearing in human interactions. This approach is also utilized to explore assumptions and concepts that have not been fully identified [19]. Since knowledge about the concept of autonomy of hospitalized patients is limited, this study was conducted using this approach.

Participants in this study included 34 persons (23 patients, 9 nurses, physician 2) (Table 1) who were recruited through purposeful and theoretical sampling from internal medicine wards of three hospitals of western and southwestern of Iran.

Table1: Demographic characteristics of participants

Patients	Sex	15M, 8 F
	Age	20Y to 60Y [Mean: 33.2]
	Marriage	12 Marriage , 11Unmarriage
	Education	primary school to BS
	Length of hospitalisation	4-30 days [Mean:8.5]
	Length of illness	1-7Years [Mean:6.5]
	Number of hospitalisation	1-14N
	Wards	2 Orology , 5 Haematology, 6 Nephrology, 3 Endocrine, 2 Respiratory, 1 Gastroenterology, 1 Kidney Transplantation, 3 General
Nurse	Sex	7 F, 2 M
	Age	23-35Years [Mean: 29.4]
	Marriage	5 Marriage, 4 Unmarriage
	Education	BSN
	Working experience	1-12Years [Mean: 6.3]
Physician	Sex	1M, 1 F
	Age	Mean 32.5 Years

Three first participants select through purposive sampling, with considering the inclusion criteria, longer hospitalization, more desire for interview and more experience of hospitalization. Based on analysis of three first interviews other participants select by theoretical sampling. For example in an interview, said patient "*The doctor does not tell us about the disease or what's tests or what's medication*" then researcher decided interview by a doctor to understand influence of physician in patient autonomy. When the doctor asked how oriented patient before intervention?" answered "*We do not explain everything, because he/she doesn't question or no time*". Thus concepts were established like *patient not involved in interactions* and *manpower shortage*. Then researcher decided that in a later interview with patient asked the reasons for not engaging in interactions. As well as to provide a broad and deep data was used maximum variation sampling. In order to affecting factors such as demographic variables was considered in sampling.

Patients' inclusion criteria were proficiency in chronic disease recognized by a physician and hospitalization for treatment, Persian language, hospitalized for at least three days, full consciousness, no history of cognitive problem and mental illness, no acute and emergency condition, and ability to communicate and transfer experience, emotions, and reactions to the researcher; the inclusion criteria for the medical team were proficiency in Persian language, work experience in internal medicine ward at least one year, and ability to communicate and transfer experience, emotions and reactions to the researcher.

In grounded theory criteria for determining the number of participants is data saturation. In the present study, the data were saturated after 30 interviews, and 4 more interviews were conducted to ensure saturation, the information obtained from these extra interviews confirmed the information obtained from previous interviews.

The primary method of data collection in this study was in-depth unstructured interviews. Interview began with a general and open question. For example, the patients were asked "tell your experience of a day in the hospital," or the medical staff was asked "tell your experience of a working day." To obtain deeper and more complete data, and in order to better understand the speech of the participants, probing questions were asked. Questions like "what do you mean of ...? Explain this further? Give an example?" After several interviews and clarification of basic concepts, for a deeper understanding of concepts and to slowly fill the existing gaps, the interviews were gradually diverted toward semi-structured interviews. The duration of interviews varied from 20 to 65 minutes. All interviews were conducted individually in a quiet room at the hospital. Other methods of data collection in this study were unstructured observation and field notes. For unstructured observation, the researcher frequently observed behaviors and interactions of nurses and doctors with patients after coordination with the ward chief. The observations were noted in real situations and were recorded in detail at the end of the day. Field notes from interviews and daily informal conversations between the researcher and the participants were also recorded.

The obtained data were analyzed using the method of Corbin and Strauss (2008) which consisted of two parts of conceptualization, to extract the concepts and the main categories, and combination and integration [18]. The researcher began the analysis after the first interview. Following several times listening to the recorded interview, the researcher transcribed and transferred it to the MAXQDA-10 (software that has a lot of ability to organize text

data), and finally began analysis by encoding the data. The initial codes were extracted according to similarities and differences and then classified to form the categories (Table 2).

Table 2: Example of coding, subcategories and categories

Interview content	Primary code	Subcategories1	Subcategories2	Category
Now that I'm fine, I doing my work, for example: I take my breakfast, I go to the bathroom, take something from refrigerator, I change my bed sheets	- Improving the physical condition - eating alone - bathing alone -removing something from refrigerator alone - changing sheets alone	doing daily living activities alone by patient - doing self-care activities alone by patient	Self-care	prove their ability
Before transplantation, I take book from hospital library and read it, then doing my learn for exmple: I observe hygien, I whashing my hands, I masking.	- take book from hospital library -read book in hospital -observe hygien after increasing knowledge -washing hands after increasing knowledge -masking after increasing knowledge	-read a book reated to dieasis by patient - impelemetation of acquired knowlgedge in hospital	Self- learning	

In order to identify the data that related to context, process and outcome was used of analytical tools for example questioning (sensitizing, theoretical, practical and guiding questions), making comparisons (constant and theoretical comparisons) and various meaning of a word with attention to body language and feeling.

Throughout the analysis process, the researcher recorded his thoughts and interpretation of the data as memos. The data obtained from unstructured observations and field notes were transferred to and analyzed with MAXQDA-10. Last stage the research team examined the categories and perceived links; discovers ‘umbrella terms’ under which several categories fit, as a result of comparing each category with other categories to see how they connect. The umbrella term can thus be seen to encompass several categories. In this stage researchers writ story line, Simultaneously, researcher repeatedly read concept, categories, memo and diagram. For example, several of the categories appeared to allude to a similar process of independent use strategies for adaptation with the existing conditions then core category accommodating autonomous was induced.

To prove trustworthiness, four main criteria must be met: credibility, transferability, dependability, and confirmability [20].

To establish credibility, the strategies of prolonged engagement, triangulation, member check, peer check and persistent observation are applied. Prolonged engagement is the investment of sufficient time to good relationship , to several interview, to build trust, and to learn the data. The participants were encouraged to support their statements with examples, and the interviewer asked follow up questions. Furthermore, the researcher studied the data from raw interview material until the theory emerged to provide the domain of the phenomenon under investigation. The process of data collection and analysis lasted for duration of 18 months. Triangulation is the use of evidence from different methods, sources and participants. To ensure methodological triangulation, data were gathered by means of in-depth interviews, observation and field notes. Data triangulation in this study was provided by the various data sets that emerged throughout the analysis process: raw interview material, codes, concepts, and conceptual saturation. Participants triangulation in this study was secured by patients, nurses and physicians interview. Observation done in morning and evening to confirm the findings that came from the participants, participants were asked to verify the collected data and confirm the researcher’s interpretation. They were also asked that they would confirm the findings to their peers. Persistent observation means recognition those characteristics and elements that are most relevant to the problem or topic under study and focusing on them in detail. Developing the codes, concepts, and the core category helped us examine the characteristics of the data. We constantly read the data, analysed them, theorized with them, and reconsidered the concepts therefore. We recoded and relabelled codes,

concepts, and the core theme. We studied the data until the final theory provided profundity. Transferability can be proven by deep description. Descriptive data (setting, sample, sample size, sample strategy, demographic, inclusion and exclusion criteria, and interview procedure) are provided to enable readers to make a transferability judgment. To prove dependability, one checks whether the analysis process is in line with accepted standards. An academic auditor reviewed the analysis process and records for accuracy and dependability. To prove confirmability, one must cover inter-subjective characteristics of the data. Two academic auditors reviewed the findings to see if they followed from the data (raw data, analysis notes, code notes, process notes, and report).

This study is part of a nursing doctorate thesis approved by the Tabriz University of Medical Sciences and the ethics committee of the university. Approval of authorities in the research field was obtained before launching the study. At the beginning of the interview, basic information about the research were provided to the participants; they included the study objective, the mode of interview, ensuring the confidentiality of information, the right to participate or withdraw from the study, ensuring the storage of sound files in a safe place, and their deletion after completion of the notes and finalization of the study. Written informed consent was obtained from them. Observation was performed with prior notice to observe the ethics.

RESULTS

Conceptualization, constant comparison, and combination and integration of data resulted in 5 main categories and one central category. The five main categories included *exposure to paternalism*, *attempts to express their opinions*, *attempts to prove their ability*, *attempts to shared decision-making* and *attempts to self-determination*. The central category was *accommodating autonomous* which demonstrated the perception of chronic patients of their autonomy during hospitalization.

Exposure to paternalism

Data analysis and evaluation of interviews and observations showed that patients at the beginning of the hospitalization encounter paternalistic relationship. Patients accept orders by the treatment team to minimize stress condition and they acted with what others said.

"Doctors make decisions for us. We cannot say anything. They say that they are doctors and it is nothing to do with us". (Patient No. 13)

Patients think that consent is a legal process, through which they had to pass to take the subsequent measures. Therefore, they signed the consent without hearing a full explanation of the content and a necessary action to be taken.

"I don't read inform consent, also did not explain to me just finger, since for the sickness and illness people do not track it, that for what it is. Read it. People think a law and a step progress to the next stage". (Patient No. 7)

Attempts to express their opinions

Patients after admission are faced with new needs. They seek strategies that satisfy your needs to others explain that they are independent.

Behaviors such as asking question, objecting, expressing requests, and disaccording demonstrated attempts to express their opinions.

Analysis of the participants' statements indicated that numerous questions are arisen in the patient in a new situation for which he is seeking responses from nurses and doctors. Often the questions included medications, discharge, nursing care, diagnosis, testing, nutrition, follow-up, visit time, ward environment, and disease.

For example researcher in one of his observations on the ward observed that when the nurse medication to the patient without explaining to him, the patient take the drugs and asked *"what is this brown medicine, what it did for me, how long should I eat it, does not effect on my other drugs, what problems may create for me"*. In this way he seeks knowledge.

To meet new needs arising from changes in lifestyle and disease, the patients frequently announce their requests to doctors and nurses; for example, replacement of IV, urine bags, discharge, visit of doctor, removal of tubing,

changing sheets, use of wheelchairs, replacement of the bed and room, to get timely treatment, receiving analgesic, using bathroom, changing the doctor, and to be aware of the diagnosis.

"Sometimes I have headache then I request an analgesic ". (Patient No. 20)

There are situations in hospital which are not pleasant for patients and cause them to object, for example regarding the food quality, noise, not opening serum, form of wake up, mode of venepuncture, not giving medication on time, large number of students, error in medication, crowded room, and student's work.

"In the morning I'm wakening with high noise. I objected 2 times ". (Patient No. 16)

In hospital there are conditions which patients are unwilling to experience so they express their opposition, for example, they may disagree with the use of drugs, IV insertion, putting thermometer in mouth, and doing some procedures.

" I said I did not need an IV Cannula. I haven't yet been prescribed any drugs or serum, I did not permit " . (Patient No. 2)

Attempts to prove their ability

After the patient regained their physical health partially, they were involved in their care during stay in the hospital. Self-care was a concept that described patients' activities to meet their situational and diverse needs (during hospitalization). Activities such as eating, changing clothes, changing sheets, use of toilet, use of drug, insulin injection, bathing, walking, following-up tests, personal hygiene, and personal habits were issues that explained the patient's self-care.

"Now that I'm fine, I doing my work for example, I take my breakfast, I go to the bathroom, take something from refrigerator, I change my bed sheets" (Patient No. 8).

The participants' experiences also indicated that patients increase their knowledge to perform better the self-care activities. So they try to collect information from various sources such as book and web. This information helps patients in self-care.

" I have read about my illness on the Internet, We all know that we have to keep taking them, on and on, for good ". (Patient No. 9)

Attempts to shared decision-making

Patients who had more knowledge about the disease and its treatment. They try involved in decisions related to their health care. They after consultation, listening to descriptions of the treatment team, views exchange and mutual agreements their participation in decisions.

Analysis of the participants' statements indicated that patients who relied on their doctor or nurse for their experience, consulted them before treatment decisions. They also consulted with family or with other people with hospitalization experience before making decisions. These consultations were often regarding selection of the physician, changing medical center, medical services, staying in the ward, discharge, and drug consumption.

"I talk with nurse about changing medical center". (Patient No. 17)

In case of consulting a nurse, the committed nurses provided accurate information and consulted for decision-making.

"I chose my physician after consulting with nurse. She suggested seeing Dr. ... ". (Patient No. 11)

According to the participants' experiences, patients listened to descriptions of the treatment team about therapeutic interventions before decision-making.

"Before giving a new test, my doctor describes me about". (Patient No. 15)

Patients were announcing their opinions during appointment with doctor or nurse.

"For example, today he came and I told him that my water body increase with serum, please stop it". (Patient No. 16)

Doctors, who were aware of and respected the rights of patients, cared more about their opinions.

"The doctor consults with me, and if there is something he explains". (Patient No. 12)

Patients and the treatment team reach to a bilateral agreement for taking measures after exchanging information.

"For example, I said, my stomach has pain. Please don't give me pill, please give me syrup, he said ok and he change my medication". (Patient No. 15)

Attempts to self-determination

Patients who had experienced longer disease eventually reach the stage of self-determination. Informed consent, self-selection, self-decision-making were important aspects of self-determination.

The participants' statements indicated that patients with hospitalization experience had more knowledge and did not sign the consent without acquiring knowledge of its content. The patients wanted to read the contents of consent and in case of doubt and questions, they asked the treatment team.

"That day, when I wanted to go the endoscopic, they gave me a consent form. I read it and then signed". (Patient No.11)

The participants' experiences about self-selection indicated that patients became aware due to seeking information and frequent hospitalization. They chose different situations. For example, a patient who had previously undergone a physician selected the same physician during hospitalization. They also chose their sleep hours, performance of procedures, nurse, room and bed, companion, discharge, wearing uniform, and venepuncture.

"For example, I said do not this room, I prefer the other room. They respected my choosing right. I mean, they gave me the authority to select my room". (Patient No. 3)

In different positions, patients with prolonged disease and frequent hospitalization made decisions after collecting information and according to their preferences and values.

"Yesterday they want send me to dialysis but I don't accept, I want go dialysis my schedule ". (Patient No. 5)

Accommodating autonomous

To accommodating autonomous means that patients during hospitalization pursue strategies independently that are compatible with the existing situation. They are based on properties, unique to this person, and flexible in changing health conditions and life situations that patient following them autonomous.

The patients' experiences indicated that they were trying to respond to the faced situation through strategies and activities such as exposure to paternalism, attempts to express their opinions, attempts to prove their ability, participatory decision-making, and self-determination, according to the current context. Exposure to paternalism reflects the fact that patients accept the comments of others who determine the best option for them at this time until they adapt with condition. Attempts to express their opinions emphasizes that patients recognize the new conditions of life and try to adapt themselves through communicating with others. Attempts to prove their ability means that patients start and finish the activities necessary for their care relying on their own abilities. Participatory decision-making represents the fact that people make decisions by participating equally with others. Self-determination means to make decision without compulsion. People with chronic illness are compatible with new situation in their lives by different activities that doing autonomous. From an analytical viewpoint, accommodating autonomous is a construct of joining various dimensions of autonomy. The synthesis of diverse dimensions of autonomy arises in various ways, depending on health status, treatment, social context, familial patterns, information, experience and skills, type of communication, life history, and personal approach. Thus, the mix of the dimensions of autonomy is not fixed, but rather a combination of what seems most appropriate at a specified time.

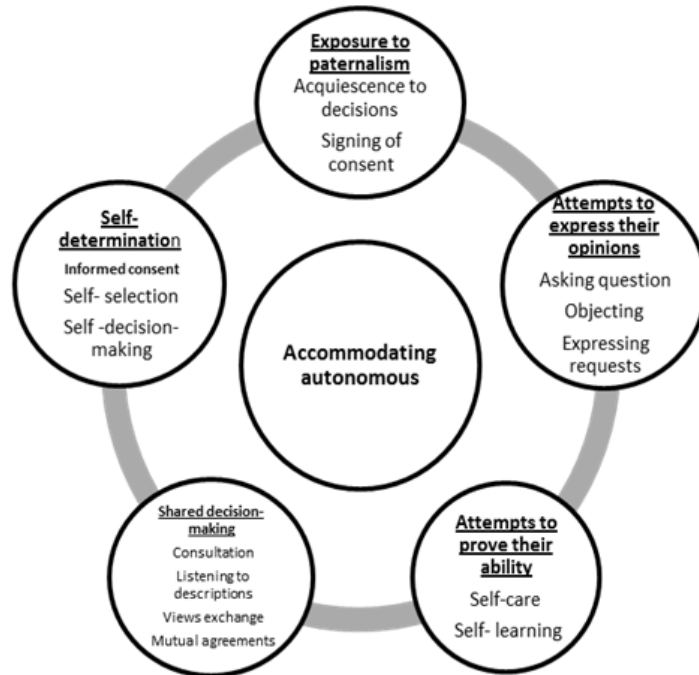


Figure 1: Dimensions of Chronic Patients' Autonomy in Iranian hospital patients

DISCUSSION

Result of our study indicated that patients for control of your life quickly and to act obligations follow ways which enables them to be compatible with the existing conditions. The chronic patients autonomous follow strategies to manage different situations and adapt to those situations. These strategies are unique and vary depending on the conditions.

Husted's (1997) introduces autonomy is process that person chosen freely fit with life and decision making autonomous [21]. Then Husted's (1997) definition of autonomy overlap with accommodating autonomous, because someone with chronic condition realizes autonomy in a way that suits only him/herself. Chronic patients may take several courses of action simultaneously, which, from a theoretical stance, are apparently contradictory, but this does not bother them. Husted (1997) stresses that people create valuable options that fit the individual unique situation and that people take responsibility for following specific paths rather than others. On the other hand, Husted provides a general definition of autonomy, but does not attention to contextual features [21]. In contrast, accommodating autonomous accentuates the fact that the autonomy of chronic people is context related.

Agich's (1993) concept of actual autonomy also comes close to accommodating autonomous. He states that autonomous people are situated in social contexts so that option is always contextual. His explanation of autonomy emphasis the fact that the social environment is important to the fulfilment of autonomy [22]. Some dimensions disagree Agich's concept; for instance, self-determination where people decide by themselves without interference from others. Nonetheless, there are dimensions (for example, shared decision-making) that highlight the importance of the social context in achieving autonomy. Theorists like Moody (1992) and Tronto (1993) and researchers like Heimerl and Berlach-Pobitzer (2000) affirm that the formal and informal social context is essential to autonomy [23, 24, 25]. However, much theoretical literature [12, 26]; as well as experimental study [27, 28] focuses mainly on autonomy within the clinician-patient communication. Life with chronic disease encompasses far more than medical issues. This research shows that the autonomy of people with chronic disease grows out of the treatment team-patient relationships, in spite of these problems. The mix of these elements implies that life with chronic condition is complicated and multi-layered; autonomy is therefore complex and dynamic. Accommodating autonomous recognizes that there can be a variety of combinations of dimensions of autonomy that will not always be the same. Then in this study autonomy is a multi-dimensional conceptualization that several dimensions of autonomy arise

simultaneously. Proot *et al.*(2000) describes three dimensions of autonomy. She reminder that these dimensions are related, but claims that they occur sequentially and not simultaneously [29]. Poort *et al.*(2000) study indicated that patient autonomy changed and improved over time [29]. Agich's (1993) that acknowledge autonomy static concept but a dynamic and vary over time [22]. Schermer (2001) and Van keleffen *et al.* (2004) describes autonomy is the multi-dimensional concept[30, 17]. Moser *et al.* (2006) defined autonomy as competency in shaping one's life [8]. In this study patient having the abilities that allow people with diabetes to shape their own lives. These activities are unique to this person, and it is flexible in changing health conditions and life situation. In Moser *et al.* (2006) study autonomy is multidimensional and dynamic and context base, aspects may occur at the same time[8]. Some aspect of autonomy in Moser *et al.* (2006) such as identification, self-management, planned surveillance, and responsive relationships[8] were aspects that do not match with our study.

Exposure to paternalism within the nurse–patient context fits the paternalistic model [26] and the dimension of obedience [28]. Both acknowledge that patients direct themselves toward the medical norms and rules of the professional. In our study patients were compatible with routines and exiting regulations.

In countries with paternalistic health systems, some patients accept the decisions of doctors and other health-service providers as a routine, even without obtaining adequate information. Zulfaghar and Ulusoy (2001) concluded from their findings on patients' awareness of their rights that from patients' perspective, the decisions made for them by doctors is routine and acceptable, because the staff does not have time to explain and justify them [31]. In the Moser's *et al.* (2006) study, welcoming paternalism was meant to acting according to others [8]. In this type of relationship, nurses provided medical information and patients accepted the proposed treatment or delegated decisions to the nurse. In Moser *et al.* (2006) study the nurse provides treatment information, and the patient accepts the proposed treatment [8], while in our study often the nurse doesn't provide treatment information, but the patient accepts the proposed treatment for escape of problems.

According to the study by Proot *et al.* (2000), paternalism (decision-making for patient) is one of the obstacles to the patient's autonomy [29] while in current study patients accept paternalism. In Moser *et al.* (2006) study patients rarely perceive problems with paternalism [8].

The viewpoint of positive freedom and autonomy emphasizes the relationship and negotiation process to establish autonomy. According to this viewpoint, independent functioning forms during dialogue [9]. The participants' experiences in the study also indicated this dialogue. Regarding autonomy to achieve the goal, Peplau put the nurse-patient relationship at the center of his nursing theory [9]. Responsive communication was one of the categories obtained by Moser *et al.* (2006), which is formed through social interaction and includes reactions to thoughts, feelings, concerns, and habits of others [8]. In current study patients question about unfamiliar situations, and object to unpleasant stations. Relational autonomy stress that human beings act autonomously within the social context [24, 32]. Relational autonomy [33, 34] which appreciate the fact that people live within relationships could be used as the models for health care decision making in chronic disease. The revelation of information has even been supposed to be essential for autonomous decision making [12, 35]. In Van Kelffen (2004) study is proven necessity of the disclosure of information for autonomous act [17]. Carlin (2003) is writing chronic patient to gather information from a variety of sources and to consider the decision that needs to be made [36]. In our study patient search information from a variety of sources that facilitate their autonomous action with use it.

Orem referred autonomy as self-care in his theory [9]. Promoting self-care is an aspect of patient's autonomy [29] and as a nursing goal helps patients for independence, strengthens their feeling of autonomy, and supports and helps their sufficiency for self-care [37]. Current study indicated that self-care was one of the strategies used by patients to maintain their autonomy. Proot *et al.* (2000) proposed the use of self-care skills as a facilitator strategy for autonomy [29].

One of the categories in the study by Moser *et al.* (2006) was self-management which included self-care activities and skills [8]. Sendu (2013) showed that self-care was one of the aspects of personal autonomy in diabetic patients [38].

Attempts to shared decision-making within the nurse–patient communication fits with the model of shared decision-making [39] and the model of balance between self-direction and obedience [28].

Patients in present study made decisions for care and treatment issues after consulting with medical team. In a study by Moser *et al.* (2006) and Proot *et al.* (2000), one of the categories derived from data analysis was participatory decision-making [8, 29]. The study of Adams *et al.* (2000) showed that patients tended to have a participatory decision-making to start medication changes[40].

One aspect of autonomy is to make real decisions and to act on them. In this state, the individual lives for his/her real goals based on decisions and preferences [41]. In the present study, attempts to self-determination was one of the themes resulted from data analysis. Attempts to self-determination related to the nurse-patient relationship fits with the concepts of self-governance ([12], 'having a say' [27], self-determination [29], and self-direction [28]. Self-determination related to self-care is fit with autonomy as independence [25]. Autonomy as independence is seen as doing everything oneself, independently of the social context. In a study by Moser *et al.* (2006), self-determination was also one of the categories which represented personal decisions for treatment, health-related issues, and behavior [8].

The center for interpretation of patients' autonomy in clinical practice is the concept of informed consent. Informed consent is the independent authorization of the patient for medical interventions [17, 42]. The results of the present study indicated that self-determined patients gave informed consent. Iranian study indicated that most patients don't orient of consent [43, 5, and 15]. In present study dependent patients sing up consent without orient of content it. They did not have the energy to read it, while autonomous patient read content consent before singing it.

One limitation of this study was the interruption of some of the interviews for nursing care or advice; in these cases, the interview continued after the intervention. Based on research ethics, the researcher completely introduced himself to the participants and stated the research objective. Thus, it was likely that some participants observed certain considerations regarding the information provided; this was outside the control of the researcher.

CONCLUSION

Although changes in health conditions and life create serious threats for patients' autonomy, they tend to adaptation with their condition and maintain their independence. Patients were trying to communicate with the treatment team and get the information needed to use it for self-care. If they trusted the medical team, they consulted with them and made decisions with their participation. They also tended to act self-determined considering their own values and priorities. It seems that informing patients of their rights in hospital improves their attitude and develop an incentive for maintaining autonomy.

Since autonomy is a phenomenon which forms during interaction, the knowledge of treatment team on patients' rights, especially regarding autonomy is worthwhile for noticing it during interaction and for avoiding paternalism. Therefore, it is suggested to provide training about patient's autonomy and the way to consider it when contacting with patients. In particular, inclusion of subjects in this field in educational content can be helpful for medical students. Establishing guidelines for medical teams to improve patients' autonomy is also recommended. As an organization, medical team members should devote opportunities for performing activities which increase patients' autonomy. Since the treatment team has a crucial role in patients' autonomy, it is suggested to conduct a study on the experiences of doctors and nurses about patient's autonomy. Informed consent is also a major component of patient's autonomy; therefore, one can explore patients' experiences on informed consent through a qualitative research. Given the dynamic nature of autonomy, it is also suggested to explore patients' experiences after discharge.

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Conflict of interest

The authors declare that there is no conflict of interest.

REFERENCES

- [1] Carlin KM. Autonomy and health care decision making in chronic illness. PhD diss., Toronto University. 2003.
- [2] Dulce DSGC. Autonomy and empowerment of hospitalized older people: a Portuguese case study. PhD diss., Northumbria University. 2010.
- [3] Lavoie M, Blondeau D, Picard-Morin J, Jocelyne, and Picard-Morin. The autonomy experience of patients in palliative care. *Journal of Hospice & Palliative Nursing*. 2011; 13 (1): 47-53.
- [4] Vinicius CO, Kathryn MR, Manuela LF, et al. Communication that values patient autonomy is associated with satisfaction with care: a systemic review. *Journal of Physiotherapy*. 2012; 58: 215-29.
- [5] Arab M, Zarei A, Hosseini M. Awareness and observation of patients' rights from the perspective of patients: a study in university hospitals in Tehran. *Journal of School of Public Health and Institute of Public Health Research*. 2010; 8 (2):77-86.
- [6] Lindberg C, Fagerstrom C, Sivberg B, Willman A. Concept analysis: patient autonomy in a caring context. *Journal of Advance Nursing*. 2014; 70 (10): 2208–2221.
- [7] Dooley D, and Swords S. Patient autonomy: a concept analysis. *Theoretical foundations of advanced nursing practice*. <http://www.dallasdooley.weebly.com>. 2011 Accessed January 24, 2014.
- [8] Moser A, Van der Bruggen H, Widdershoven G. Competency in shaping one's life: Autonomy of people with type 2 diabetes mellitus in a nurse-led, shared-care setting; a qualitative study. *International Journal of Nursing Studies*. 2006; 43 (4): 417-27.
- [9] Moser A, Houtepen R, Widdershoven G. Patient autonomy in nurse-led shared care: a review of theoretical literature. *Journal of Advance Nursing*. 2007; 57 (4): 357-365.
- [10] Solaymanzadeh eyedesh R, Mostafave Z. Factors affecting the scope of authority, a case study on the second story of couplets. *Andishe Nvoin-e-Dini*. 2014; 9 (35): 77-98.
- [11] Ramin, F. Human authority from the perspective of Sadra and Jaspers. *Wisdom and Philosophy*. 2010; 6 (3): 7-31.
- [12] Beauchamp TL, Childress JF. *Principles of biomedical ethics*, 6rd ed., USA: Oxford University Press.2008.
- [13] Chery B, and Jacob SR. *Contemporary nursing: issues, trends & management*. 6rd ed., China: Mosby.2014.
- [14] Rahmani A, Gahremanin A, Allah-Bakhshian A. Respecting to patients' autonomy in viewpoint of nurses and patients in medical-surgical wards. *Iran Journal Nurse Midwifery Research*. 2010; 15 (1): 14-9.
- [15] Amini M, Mousavi M, Mohamdnejad M. Informed consent of patient in Tehran hospitals. *Journal of Medical Ethic and History*. 2009; 2(3): 61-69.
- [16] Darvishpoor Kakhki A, Abed Saeedi J, Delavar A, Saeed-O-Zakerin M. Autonomy in the elderly: a phenomenological study. *Hakim Research Journal*. 2010; 12 (4): 1- 10.
- [17] Van Kleffen TV, Baarsen BV, Leeuwen EV. The medical practice of patient autonomy and cancer treatment refusals: a patients' and physicians' perspective. *Social Science & Medicine*. 2004; 58 (11): 2325–2336.
- [18] Corbin J, Strauss A. *Basics of qualitative research: techniques and procedures for developing grounded theory*. 3rd ed., Sage. 2008.
- [19] Streubert HJ, Carpenter DR. *Qualitative research in nursing: advancing the humanistic imperative*, 5rd ed. Lippincott Williams & Wilkins.2010.
- [20] Lincoln YS, Guba EG. *Naturalistic Inquiry*, 1rd ed., USA: Sage.1985.
- [21] Husted J. Autonomy and the right to know. In *The right to know and the right not to know*, Edited by R. Chadwick, M. Levitt, and D. Shickle, 55–68. Avebury: Aldershot. 1997.
- [22] Agich, G.J. 1993. *Autonomy and Long-term Care*. New York: Oxford University Press.
- [23] Moody HR. *Ethics in an aging society*. Baltimore: Johns Hopkins University Press.1992.
- [24] Tronto JC. Moral boundaries: a political argument for an ethic of care. *Acta Sociologica*. 1995; 38 (4): 370-373.
- [25] Heimerl D, Berlach-Pobitzer I. Autonomy obtain a qualitative patient survey in of the Hauskran- kenpflege. In *Autonomy in the alter: studies to improvement of the Lebensqualita' t by professional Pflege*, Edited by S. Seidl, M. Stankova, and I. Walter, 102–165. Vienna: Wilhelm Maudrich.2000.
- [26] Emanuel EJ, and Emanuel LL. Four models of the physician–patient relationship. *Journal of the American Medical Association*. 1992; 267 (16): 2221–2226.
- [27] Pool A. *Autonomie, afhankelijkheid en langdurige zorgverlening*. (Autonomy, dependence and long-term care). Utrecht: Lemma. 1995.
- [28] Stu'ssger RAJ. *Denieuwe patient op weg naar autonomie*. PhD diss., Amsterdam University.1997.
- [29] Proot IM, Abu-Saad HH, Esch-Janssen WP, Crebolder HFJM, Meulen RHJ. Patient autonomy during rehabilitation: the experiences of stroke patients in nursing homes. *International Journal of Nursing Studies*. 2000; 37 (3): 267-276.

- [30] Schermer M. The different faces of autonomy: A study on patient autonomy in ethical theory and hospital practice. PhD diss., Van Amsterdam University. 2001.
- [31] Zolfikar F, Ulsoy F. Are patients aware of their rights? A Turkish study. *Nursing Ethic.* 2001; 8 (6): 487-98.
- [32] Vinicius CO, Kathryn MR, Manuela LF, et al. Communication that values patient autonomy is associated with satisfaction with care: a systemic review. *Journal of Physiotherapy.* 2012; 58: 215-29.
- [33] Sherwin S. A relational approach to autonomy in health care. In *The politics of women's health: exploring agency and autonomy.* edited by S. Sherwin and et al. Philadelphia: Temple University Press. 1998.
- [34] Donchin A. Understanding autonomy relationally. *Journal of Medicine and Philosophy.* 2001; 26 (4): 365-386.
- [35] Wear S, Moreno JD. Informed consent: Patient autonomy and physician beneficence within clinical medicine. *H E C Forum.* 1994; 6 (5): 323-325.
- [36] Charles C, Gafni A, Whelan T. Shared decision making in the medical encounter: What does it mean? *Social Science & Medicine.* 1997; 44 (5), 681–692.
- [37] Alimohamadi N, Pahlavanzadeh S, Soltani MH, Hasanzade A. Effect of self-care on quality of life of multiple sclerosis patients. *J Shahrekord Univ Med Sci.* 2001; 3(2): 79-86.
- [38] Sandu A. The social construction of autonomy and the meanings of autonomy for the diabetic patient from doctor's perspective. *Procedia - Social and Behavioral Sciences.* 2013; 93: 2130 – 2135.
- [39] Chiovitti RF, Piran N. Rigour and grounded theory research. *Journal of Advanced Nursing.* 2003; 44(4):427-35.
- [40] Adams RJ, Smith BJ, RuYn RE. Patient preferences for autonomy in decision making in asthma management *Thorax.* 2001; 56 (2): 126-132.
- [41] Sandman L, Granger BB, Ekman I, Munthe C. Adherence, shared decision-making and patient autonomy. *Med Health Care and Philos.* 2012; 15:115–127. doi: 10.1007/s11019-011-9336-x.
- [42] Nomura K, Ohno M, Fujinuma Y, Ishikawa H. Patient autonomy preferences among hypertensive outpatients in a primary care setting in Japan. *The Japanese Society of Internal Medicine.* 2007; 46 (17): 1403-1408.
- [43] Mirbager Ajorpaz N, Heidari S, Ranjbar N, Afshar M. The quality of being informed consent in patients undergoing surgery in selected hospitals in Isfahan in 2008. *Qom University of Medical Sciences Journal.* 2010; 51(3):1-8.