Self-care management is essential for effective chronic disease management. Yet prevailing approaches of healthcare practitioners often undermine the efforts of those who require on-going medical attention for chronic conditions, emphasizing their status as patients, failing to consider their larger life experience as people, and most importantly, failing to consider them as people with the potential to be partners in their care. This article explores two approaches for professional–patient interaction in chronic disease management, namely, patient-centred care and empowering partnering, illuminating how professionals might better interact with chronically ill individuals who seek their care. The opportunities, challenges, theory and research evidence associated with each approach are explored. The advantages of moving beyond patient-centred care to the empowering partnering approach are elaborated. For people with chronic disease, having the opportunity to engage in the social construction of their own health as a resource for everyday living, the opportunity to experience interdependence rather than dependence/independence throughout on-going healthcare, and the opportunity to optimize their potential for self-care management of chronic disease are important justifications for being involved in an empowering partnering approach to their chronic disease management.

Keywords: Chronic disease management, Patient–Practitioner relationships, Empowering partnering, Patient-centred care, Self-care management

While some have questioned its promise to improve outcomes, reduce costs and lower health services utilization, self-care management, nevertheless, has become the mantra of chronic disease management. Self-care management of chronic disease is defined as the involvement in chronic disease management of an educated activated patient. These patients are prepared by a proactive professional team who provide information, education and support, accessible information and delivery systems, and frequently, also are guided by lay education and support networks.

Theoretically, individuals’ involvement in self-care management of chronic disease makes sense. Much chronic disease management occurs beyond the confines of the healthcare sector, in the day-to-day arena of the individual’s life and health context. From a policy and practice perspective, emphasizing the patient’s expertise is viewed to overcome victim blaming, state control and paternalism.

Practically speaking, however, the complexities of health services delivery in the current context of healthcare do not readily nurture self-care management. Both the public and those responsible for healthcare expect intervention in keeping with the mandates of professional disciplines.
Professionals have socially, educationally and culturally entrenched professional practices and attitudes that traditionally do not encompass this direction. System trends, issues and policies related to responsibilities and accountabilities for healthcare impede the efforts of both professionals and people with chronic disease to promote self-care management. 

So how might care approaches for people with chronic disease be refined to optimize their potential for involvement while simultaneously ensuring the quality and appropriateness of health services? Should people with chronic disease be patients, persons or partners in their care?

Many disciplines and service delivery organizations espouse patient-centred care, focusing on patients as persons. Patient-centred care commonly emphasizes the integration of the patient’s care needs and agenda through effort to negotiate or find common ground in making decisions about biomedical and psychosocial problems and solutions. A few espouse relationship-centred care, encompassing patient-centredness, but focusing specifically on the nature and/or process of relating in a way that empowers patients, through the relational process, as partners in their care. In practice, intentionally or unintentionally, professional–patient interactions inevitably reflect elements of both of these approaches, varying in degree and form, across individual dyads, contexts, circumstances and time. But what the specific nature of such interactions may mean for the social construction of being a person with chronic disease characteristically remains unconsidered in the context of everyday practice.

The purpose of this article is to explore patient-centred care and the relational approach of empowering partnering as strategies for professional–patient interaction in chronic disease management, illuminating how each approach socially constructs the involvement of people with chronic disease in their care. The opportunities and challenges associated with the application of each approach are discussed, with emphasis on the roles created for individuals with chronic disease as patients, persons and/or partners in their care. Both theory and research evidence informing consideration of these options in chronic disease management are presented. The merits of the empowering partnering approach for optimizing the involvement of people with chronic disease in their self-care management are identified.

PATIENT-CENTRED CARE

The value of getting to know and understand what each patient as a person is confronting and addressing in their larger life context has been widely recognized. Accordingly, the patient-centred clinical method (Table) has been widely adopted as an approach in which the professional: '(a) explores the patient’s main reason for the visit, concerns and need for information; (b) seeks an integrated understanding of the patient’s world—that is, their whole person, emotional needs and life issues; (c) finds common ground on the nature of the problem and approaches for managing it; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship with the patient' (p. 445). The patient-centred clinical method intentionally focuses on the content of the interaction, specifically, patients and their needs. Its authors ‘have chosen not to use the term relationship-centred, concurring with Churchill (p. 116) that ‘the mistake of ‘relationship-centred medicine’ is that it confuses means with ends, stressing the interaction itself, rather than the goal that interaction should serve’ (p. 8).

In keeping with its label, the patient-centred clinical method is an objective, concrete method of communication, a technique for doing, specifically, for identifying the content to which the practitioner needs to attend to achieve patient-centred care. This rational approach is led by the professional, whose role is to explore the patient’s feelings,
ideas, fears, expectations and the effect of the illness on their functioning, formulate an integrated understanding of this bigger picture, and negotiate a ‘common ground’, an agreed course of action toward outcomes, including the treatment approach, disease prevention and health promotion. Overall, the professional has the responsibility and accountability for achieving patient-centred care. The role of the individual with chronic disease is thus that of patient, contributing content related to him/herself as a person and adhering to negotiated plans to achieve the best care outcomes.

Other patient-centred approaches generally espouse these techniques, but also feature additional tasks for the practitioner. These include giving information and/or providing education to enable the patient to take responsibility for his/her own health; embracing a philosophy of respect for and partnership with the patient; recognizing the individual’s autonomy and strength; ensuring that services are accessible and fit the patient’s context; coordinating, integrating and providing continuity of care; involving family and friends; and ‘activating’ or ‘motivating’ the patient to take control in the consultation and/or in the management of their illness. Patient empowerment is conceptualized as an ‘end’ goal, that is, an ‘expert patient’, one who is equipped and motivated to engage in self-care management as a consequence of education, skills training and motivational interviewing provided by health professionals and on-going support for self-care.

Models of patient-centredness that identify ‘partnership’ as an ingredient of patient-centred care suggest the importance of the ‘balance of power’. Communication, participation in decision-making, the mutual establishment of goals and the means to achieve them, and working together toward these goals are identified as ways to share powers, described as the professional’s giving and surrendering power, with due

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recognition that the patient may not want this power.\textsuperscript{25} Thus, power is portrayed as something that each individual in the care dyad has or does not have to varying degrees. The relational notion of synergistic ‘power with’ is not contemplated.

**THE OPPORTUNITIES AND CHALLENGES OF THE PATIENT-CENTRED APPROACH**

For chronic disease management, a patient-centred approach has the potential to achieve better care outcomes by incorporating the chronically ill individual’s personal knowledge of his/her condition, enhancing the generic expert knowledge that professionals bring to diagnosis, treatment, health promotion and education for self-care management. The patient-centred approach also may achieve fuller understanding of the illness experience, thereby compensating for the systemic pressures that focus health professionals’ attention on episodic care and short-term outcomes. Otherwise unapparent issues undermining effective treatment and follow-up also may be exposed.\textsuperscript{47,48} The patient also may become educated and motivated to engage in self-care management.

A major challenge of patient-centred approaches, however, is that they both reflect and perpetuate the practitioner’s socially constructed role as the expert. Patient involvement is invited, guided and indeed, shaped by the professional, who seeks input, asks questions, negotiates solutions and undertakes to educate and motivate the person with chronic disease. In this interaction, this individual is most likely to respond in keeping with the socio-culturally and historically engrained roles of patient and professional expert. Research\textsuperscript{21,49} has demonstrated that long term exposure to this approach puts people at risk of undermined self-efficacy and self-reliance, in turn, reinforcing passive reliance on professional services and other system resources.

Another challenge is the assumption of achieving empowerment for self-care management. Patient-centred clinical methods reflect a functionalist perspective of power\textsuperscript{50} and healthcare,\textsuperscript{51} in which the professional may achieve transfer of what constitutes conditioned power\textsuperscript{17} to the person with chronic disease. People with chronic disease in receipt of knowledge and support, hence, ‘power’, may or may not use this power in self-care management, however. For example, research has found that despite intent to comply in applying information and training provided for this purpose, 60\% of people with diabetes still do not engage in appropriate self-care management.\textsuperscript{48} Hence, patient empowerment as understood in this approach is uncertain and potentially symbolic. Overall, research suggests that the nature of the experience of chronic illness may require other strategies.\textsuperscript{32,52–55}

**THE EMPOWERING PARTNERING APPROACH**

The empowering partnering approach entails critical reflection toward knowing, understanding and applying the patient’s personal knowledge of his disease and larger life and health context, and therefore elicits content similar to that elicited by the patient-centred method. However, the patient-centred clinical method focuses first and foremost on this content, communication techniques for achieving it, and concomitant outcomes, including empowerment for and achievement of self-care management, ignoring any relational component. In contrast, the empowering partnering approach (Table) focuses first and foremost on the relational process from a subjective attitudinal stance. The content is secondary and not prescribed. Instead, the content is elicited through a process of open-ended questioning that creates a critically reflective, intersubjective, interactive working relationship, a way of being co-constructed by two interacting human beings.\textsuperscript{32}
While both communicating and relating are inevitably part of any approach to care, importantly, ‘relationship’ in the empowering partnering approach is not ‘a recurrent pattern of communication that exists between two people’ (p. 1089), as the term is often understood in professional contexts. Rather, ‘relationship’ is conceptualized as a subjectively experienced, mutually shared ‘way of being’ at the hyphen of a single ‘I-Thou’ unit, developed and refined experientially through time and mutual effort directed toward understanding how to be with one another. This stance contrasts with the traditional professional distancing, or objectified ‘othering’ characteristically adopted in professional–patient relationships, including patient-centred care approaches. It also contrasts with the transfer of power, and concomitantly, responsibility and accountability for care, from professional to patient, as in ‘expert patient’ approaches.

In empowering partnering, the roles for practitioner and patient are neither separate nor prescribed. Rather, the two form a single mutually constructed partnership in which their roles evolve, guided, not by specified techniques, but by principles informing the how to art of relating. This is consistent with the thinking of Rogers who cautioned against dwelling on methods, maintaining that such a focus emphasizes professional control and impedes focus on the dynamic, fluid changes of relating.

Four principles simultaneously inform the empowering partnering process. The emergent reflective content and the relational process together are enacted as the promotion of health as a resource for everyday living or as relational health promotion. Thus, the priority of empowering partnering is this relational health-promoting process itself, not care outcomes. Care outcomes beyond that, including self-care management, are neither predetermined nor predictable, as outcomes of this nature are mutually created through the process. Secondly, empowering partnering should be patient-centred.

Thirdly, the dyad should endeavour to avoid superimposing the professional’s expert status, knowledge and authority throughout the relational process, instead allowing an equitable or fair (not necessarily equal) balance of the patient’s personal knowledge, abilities and decision-making inclination to enter into and combine with expert knowledge throughout the discussion, in keeping with a relational definition of empowerment. Finally, the dyad should aim first to achieve mutual identification, affirmation and reinforcement of the strengths of the individual with chronic disease so that (s)he is enabled to build upon these. This focus does not preclude the usual ‘healthcare’ focus on problems and their solution as the need arises. However, the primary focus on strengths is essential to the pursuit of health as a resource for everyday living.

An art rather than a skill, practical application of the empowering partnering process has been illustrated in detail elsewhere. The professional enters into the empowering partnering relationship by enacting and maintaining ‘unknowing’. Unknowing is a conscious process of introspective decentering from one’s own principles for organizing the world ‘to become metaphorically eclipsed by a patient in order to know the patient’ within a shared intersubjective understanding (p. 125). This way of being is achieved relationally, through non-verbally inviting and enabling the person seeking care to enter into and be with the practitioner as a partner in care, if, as, and how he/she chooses. Unknowing creates a mutual, intersubjective space for understanding and acting in partnership, using critical reflection as an intuitive process of surfacing and co-creating experiential knowledge for care management.

The professional and patient co-construct and refine empowering partnering through critical reflection, asking questions toward answers that surface and integrate the experiential and personal knowledge of the person with chronic disease with that of the practitioner. Over time, answers develop and
synthesize understanding of the person’s broader life and health, their needs, motives, expectations, goals, strengths and resources for life and health, integrating this understanding with the expert and experiential knowledge of the practitioner. Issues are mutually analyzed, directions developed, and actions decided against the repertoire of experience, knowledge, abilities, resources and decision-making authority that each participant contributes equitably to the partnership. The attitudinal stance conveyed by the process of exploring this content has been found to promote the social construction of a trusting, meaningful relationship, shared knowledge and understanding of the person with chronic disease, and interdependence in healthcare.32 The open-ended questioning throughout the critical reflection process also nurtures the partnership’s mutual reflection-in-action and reflection-on-action,64,65 synergistically creating new understandings, including new self-understandings, new ideas and new strategies32 for the pursuit of health.66

The combined effort toward relationship-building and creating a mutual conscious awareness of and attention to the individual’s health nurtures knowledge of self, self-efficacy and perceptions of relational support for self-care management.32 Inasmuch as the person with chronic disease feels that the process affords an equitable, or fair sharing of knowledge, status and decision-making authority in a care relationship61 and an opportunity to be involved, if and as (s)he chooses to partner, empowerment is achieved.32 Empowerment in this instance is an on-going process, or ‘power with’, not an outcome attained through the sharing or transfer of power.

Patients may not have had formal training in reflection-on-action and reflection in action,64,65 and initially may not be accustomed to being this way. As well, although their experiences are unique, patients often have had social-historical exposure to more traditionally constructed professional–patient relationships. Therefore, the professional generally has to take the initiative to begin the social construction of the mutual process of empowering partnering. This requires conscious effort, not only because professionals also generally have been exposed to more traditionally constructed professional–patient relationships, but also because professional education and the practice context do not readily foster reflection-on-action and reflection-in-action. Once the process has begun, however, the professional and the patient work with one another, responding sensitively to the patient’s interests, inclinations, abilities and desires with regard to partnering. Like dance partners, the two together develop and refine their empowering partnering experience through the process. The art of empowering partnering takes time to develop, dynamically unfolding, evolving and improving across clinical encounters.32,67

THE OPPORTUNITIES AND CHALLENGES OF THE EMPOWERING PARTNERING APPROACH

The empowering partnering approach enables people seeking the services of healthcare professionals to be themselves, thereby optimizing their opportunity to realize their potential for self-care management through a self-determined role as patient, person or partner at any one moment in time. Like patient-centred communication, empowering partnering aims to achieve person-oriented recognition and involvement of the individual with chronic disease in their care management. In so doing, both strategies promote the social construction of life with chronic illness,68,69 the identity or biographical ‘work of illness’69. Empowering partnering’s relational approach and focus on health as a resource for everyday living affords additional opportunities, however. This approach engages the person with chronic illness in the ‘interational work’ of pursuing pre-illness health.
and life-related goals and relationships, and the ‘trajectory work’ of managing and regulating the illness experience.\textsuperscript{69,70} Thus, empowering partnering simultaneously fulfills fundamental social needs for affection, confirmation and status\textsuperscript{71} and ensures that the individual’s subjective will and feelings are incorporated into care management strategies.\textsuperscript{59} Accordingly, empowering partnering nurtures a more self-actualized sense of one’s self and one’s capacity for health, despite the ever-present disease, as well as the individual’s capacity for involvement in self-care management of chronic disease. These benefits are reciprocally reinforced over time and continuity of relationship, across all contacts between patient and any one professional or professional practice team.

Ultimately, the partnering process enables the individual with chronic disease to exercise autonomy where and when (s)he feels able and willing to engage in mutually creating and executing healthcare. As engaging in empowering partnering is a matter of choice, not professional opinions on the individual’s ability and/or right to be involved, unwelcomed or inappropriate shifts of responsibility and accountability for care,\textsuperscript{72} hence, power, from the professional to the patient are avoided. Instead, empowerment is experienced as an on-going element of the process of relating, building relational trust.\textsuperscript{32,73} Relational trust enables individuals to address the uncertainties and difficulties that accompany chronic disease. Empowerment thus becomes power with, rather than self-surveillance premised on standards set by the expert.\textsuperscript{74,75}

‘Power with’ differs from the ‘approximately equal’ balance of power\textsuperscript{76} contemplated in patient-centred approaches, and from the transfer of power associated with the ‘expert patient’ model.\textsuperscript{17} ‘Power with’ is patient-led or ‘driven’. That is, it is determined by what the patient helps to construct and/or consciously identifies as a fair contribution of knowledge, abilities and decision-making authority. This does not mean that patients make the decisions about and manage their care, a shift of knowledge and authority, hence, power, from the professional to the patient. Rather, ‘power with’ means that the professional responds sensitively to the individual, the context, and the circumstances at hand, appropriately taking action and providing expertise if, where, when and to the degree needed, in a mutually created relational manner.

Like patient-centred care, the empowering partnering process is not without challenges. Giddens\textsuperscript{77} describes the complexity of this challenge at the individual level, distinguishing between discursive and practical consciousness of the task at hand. The patient and practitioner may achieve discursive consciousness through their mutual critically reflective dialogue. However, their practical consciousness of the process of empowering partnering more readily lies on the periphery of consciousness, compromised by the inconsistencies and contradictions rampant in the social nature of their ‘healthcare’ context. Both public and system expectations of health professionals pressure practitioners to assume responsibility and accountability for the management of scarce resources, including the use of professional time. This reinforces both the professional’s and the patient’s focus on immediate problems and the tasks required to achieve defined biomedical outcomes. Such inconsistencies and contradictions have been identified by those concerned about expert patient programmes.\textsuperscript{1}

The current context of ‘healthcare’ also both demands and respects professionals’ expert knowledge, skills and decision-making in doing to and doing for patients to achieve ‘healthcare’ outcomes. Organizational infrastructures focus attention on the management and coordination of services. Policies and procedures emphasize time for tasks. Reward systems recognize and remunerate tasks performed. In this context, professionals quite understandably focus on their own unique contributions, each discipline laying claim to select sets of responsibilities and accountabilities, within
sacrosanct role boundaries reinforced by professional education, legislated mandates and psychological premises of professional self-esteem. This focus all but precludes trusting and engaging the knowledge, skills and decision-making abilities of persons with chronic disease. Thus, the empowering partnering approach requires continuous reflection-on-action and reflection-in-action in a context that severely thwarts reflection.

PATIENTS, PERSONS OR PARTNERS: WHERE FROM HERE?

If any individual’s capacity for health and involvement in self-care management is to be optimized, then society at large, healthcare policy, healthcare infrastructures and health professionals alike all have to both reflect and promote this orientation. The empowering partnering approach is a micro-level strategy for interacting with people with chronic disease toward the achievement of this aim.

Clearly it is not enough to simply re-write the principles of practitioner–patient interaction. Research has confirmed the challenges to more holistic relational and self-care management strategies emanating from the healthcare system, the infrastructure of service delivery, and from individuals, both practitioners and people seeking their care. Healthcare continues to focus on disease and medical care management, with professionals both assigned and assuming the authority for care management, and people with chronic disease relegated to the role of ‘sick’. As the cost-efficient attainment of medical outcomes has been the priority, attention to the process of care continues to be extensively undermined. The social construction of a different way of being with people with chronic disease requires change in all of these contextual dimensions of healthcare.

At a societal level, more critically reflective publicizing of the limitations of biomedical science, the ‘fix it’ orientation to healthcare management, and the relative reverence for and reliance on scientific knowledge and technology, as compared to that of the arts and humanities, may help. Health policy, including the World Health Organization’s agenda for health promotion and chronic disease management, still predominantly biomedically focused, might better reflect the most current definitions of health and health promotion and better address relational issues. The education of all health professionals needs to place more emphasis on fostering the affective, attitudinal and relational components that constitute the art of professional practice. Professional and healthcare organizations, their decision makers and professional practitioners alike need to give more considered attention to the pursuit of evidence-based practice, outcome-driven benchmarks and standards of practice. Professionals’ exercise of experiential knowledge and intuition in artful practice and patients’ expression of uniquely individual personal knowledge, skills, wishes and will both need to be factored into such directions.

Such changes only come, however, when critically reflective, conscientious individuals representing professional and public jurisdictions alike need to confront the societal, system, organizational and individual factors that shape human interaction. As elaborated in social theory, the human agency of individuals who comprise society and, its subset, organized healthcare, make these infrastructures what they are, just as society and its subset, organized healthcare, make the human agency of individuals within these infrastructures what it is. The actions of individuals and the collective social structure are simultaneously constituted in a complex relational process in which neither has primacy. Each exists because of the other. Thus, the social construction of a different way of being in professional–patient interactions requires all individuals concerned about the involvement of people with chronic disease to take deliberate action.
Health and illness are social constructions largely reinforced through interactions with professionals who are socially assigned the authority to label, treat and manage illness. Self-care management similarly is socially constructed. Hence, how health practitioners view and engage those with chronic disease plays a critical role in shaping these individuals’ lives and health.

The unique preference of any individual with chronic disease for both the nature and extent of involvement in his/her care management is undeniably a fundamental consideration. While loss of one’s sense of internalized security and one’s social and personal identities may be at the root of the experience of powerlessness amongst adults with chronic illness, issues of choice and participation also are problematic. People’s preferences for involvement may range from compliance to interactive partnership. Thus, in keeping with a patient-centred approach, involving people with chronic disease as partners in their care requires individualization.

At the same time, however, the benefits of involvement merit consideration. Research to date has focused primarily on involvement in medical decision-making, decision-making in chronic disease management and self-efficacy for self-care management, emphasizing dichotomized roles rather than holistic partnering. In one rare instance, practitioners and patients were observed to achieve the ideal of co-creating person-specific knowledge, using focused communication and reflection to inform problem-solving. The researchers concluded that it is not whether patients wish to be involved, but how they are involved and engaged that matters.

The how of empowering partnering is an example of a ‘new order’ of healthcare premised on the understanding that all knowledge, including scientific knowledge, is both personal and co-created through social interaction. Although rooted in the assumptions and beliefs of the constructivist paradigm, this orientation is not ‘linked with new age politics, post-Marxist prescriptions’, nor the expectation of patient agency in the form of ‘coping’ and self-care management that (s)he may be unwilling or unable to enact. Rather, the empowering partnering process is a template for the discourse of ‘walking with’ one another in a critically reflective relational process that holistically evolves shared responsibility and accountability for care management with no a priori assumptions about the patient as agent, and no singular exercise of power by either the practitioner or the patient.

Research has begun to portray the impact of attending to professional–patient interactions. The patient-centred approach in physician–patient communication has been associated with improved outcomes, including patient satisfaction and compliance, reduction of concern, symptom reduction and improved physiological functioning. Self-esteem, self-efficacy and empowerment develop through involvement. Beyond this, however, patient involvement has been found to have a positive effect on health status, self-care management, coping behaviour and satisfaction with care.

The empowering partnering approach has been tested in a large randomized controlled efficacy trial. The intervention consisted of 12–16 interactions between 198 seniors requiring in-home services for a diversity of chronic diseases and trained study nurses. These dyads averaged 10.5 h of contact over a 22-week period, spending that time in critical reflection on the senior’s life and health, their needs, expectations, goals and resources for optimizing health with chronic illness, their thoughts and ideas about strategies for pursuing health, and their experiences of doing this. As compared to 198 subjects engaged in the usual interactions throughout their home care, those who participated in the empowering partnering approach demonstrated significantly greater independence, perceived ability to manage their own health and quality of life,
and significantly lowered unmet information needs \((p = 0.035)\), with trends persisting 1 year later. While the approach is not aimed at time- and cost-efficiencies, the intervention participants averaged 8.2 fewer days in hospital, and used fewer in-home services during the 1-year follow up. These findings suggest that while empowering partnering obviously takes interaction time, overall, it may ultimately conserve this precious practitioner resource, in keeping with system goals. A subsequent quasi-experimental organization-wide effectiveness trial in the home care sector demonstrated that those involved as partners in their care required fewer in-home services, suggesting enhanced independence. Qualitative investigation has identified that individuals with chronic disease experience enhanced self-esteem, well-being, involvement and control, while practitioners describe the experience of more professional practice and greater job satisfaction.

Studies comparing patient-centred and empowering partnering approaches have not been undertaken. However, the potential benefit of the empowering partnering approach is suggested by a systematic review of 30 rigorous studies: 20, reflecting a ‘patient-centred’ approach, and 10, ‘patient activation’ consistent with fostering self-managed care. Patient activation was more strongly associated with better physical health outcomes. Further research is needed, but overall, the empowering partnering approach clearly has potential benefits.

**CONCLUSION**

From the perspective of individuals with chronic disease, the diagnosis of incurable illness means the loss and re-creation of one’s previous sense of self and self-care management. This re-creation is informed by all social interactions. As one never finally crystallizes oneself, but rather, is constantly in the process of becoming one’s self, the patterning of living with and managing one’s chronic illness is reinforced, modified and evolved over time through all contacts, perhaps particularly through those encountered in the course of seeking healthcare. From the perspective of professionals, the Alma Ata states a broad principle that recognizes health as a resource for everyday living. Statements of professional colleges increasingly call for partnership. Thus, for both patients and healthcare professionals, whether practitioners view and engage people with chronic disease as patients, persons or partners in their care is exceedingly important.

Both the patient-centred clinical method and empowering partnering tailor interactions to consideration of individuals’ unique contexts, needs, expectations and motivations, thereby affording an individual with chronic illness the opportunity to socially construct the ‘what’ of life’s content, a fresh meaning of his/her life with chronic illness that transcends suffering, achieves reconnection with others, and affords healing. Empowering partnering differs, however, by focusing inter-subjectively on the interaction process, the how of professional–patient relating, facilitating the forever on-going social construction of the person with chronic disease through relationships with healthcare providers. Thus, empowering partnering shifts the relational perspective from ‘empathetic witnessing’ and healing and dichotomized roles to the social construction of being with one another in a care partnership focused on health.

Empowering partnering also emphasizes building upon the strengths of the individual with chronic disease, thereby constructing health as a resource for everyday living rather than ‘illness talk’. Enacting this understanding of health is particularly important for people with chronic disease, as health as the absence of disease or as a state of complete mental, physical and social well being is not a realizable outcome. Health as a resource for everyday living can and does co-exist with chronic disease.
All individuals, including those with chronic disease, both subjectively experience health \textsuperscript{116} and inherently have agency in co-constructing their health.\textsuperscript{111}

Managing health defined in this way requires a significant re-writing of the roles of practitioners and patients/clients.\textsuperscript{14,116} The participation of the person with chronic disease is not framed by a practice perspective focused principally on biomedical disease management\textsuperscript{117} and motivating\textsuperscript{45,46} and facilitating desired psychosocial health behaviours.\textsuperscript{13,45,118,119} Rather, in empowering partnering, the participation of the person with chronic disease is framed from the perspective of the person who lives life with chronic illness. Enacting care in keeping with this understanding, then, requires that patient values and goals not only shape the outcomes of healthcare, as is theorized in patient-centred care, but also shape the means of socially enacting that care on an on-going basis with whatever focus, and with whatever direction that person envisions.

This orientation of the empowering partnering approach is not only in keeping with the growing emphasis on health,\textsuperscript{61,118–123} but also fits with the Shifting Perspectives Model of Chronic Illness.\textsuperscript{124} The empowering partnering approach recognizes that care is dynamic, that while people with chronic disease have needs for expert medical knowledge, skill and intervention, they also have needs for autonomy, independence and self-actualization. Empowering partnering enables the practitioner to be with the patient if, as, and how that person’s individuality, context and circumstances dictate, but also fosters and heightens the possibilities for wellness as foreground. As well, the empowering partnering approach is congruent with efforts to confront the paternalism and constrained personal autonomy inherent in traditional models of professional practice and to encompass critically reflective practice and social inclusion\textsuperscript{72}, as illustrated by both qualitative research\textsuperscript{125–127} and critically reflective papers.\textsuperscript{128,129}

To the extent that it is embraced and applied, the empowering partnering approach creates a healthy interdependence in the professional–person relationship that encompasses and enables both any necessary professional care/services and self-care management of chronic disease. Such interdependence in relationships with health professionals is crucial to avoiding unwitting abandonment, leaving the individual with all of the responsibility and accountability for the management of chronic disease.\textsuperscript{17,130} In this way, people with chronic disease are first and foremost, persons, secondly, involved appropriately as partners, and thirdly, supported and cared for as patients in accordance with their unique individual needs.

Change comes through a combination of critical and innovative thinking, an openness to new ideas, and a willingness to question and alter socio-historically and culturally engrained values, attitudes, beliefs and norms at societal, political organizational and individual levels. Involvement in self-care management is legitimately an ideal approach for people with chronic disease, but only if it is undertaken for the right reasons, and in the right way, at the right time and place, with sensitive responsiveness to the need for interdependence in the full management of chronic disease.\textsuperscript{131} Involving those with chronic disease in their care has implications for their self-esteem, self-actualization, quality of life, and ultimately, for their health. It stands to reason, then, that professionals, policy makers, decision makers and the public alike must consciously attend to the social construction of involvement in all healthcare interactions related to people with chronic disease. People with chronic disease need to inform the nature of such interactions, determining through the process, their role as patients, persons or partners.

End note

The limitations of the term ‘patient’, particularly its inappropriateness for referring to people with chronic disease engaged as
partners in their care and its rejection by several health and social service disciplines, notably nursing, occupational therapy and social work, are hereby recognized. With apologies for these shortcomings, the term has been used consistently throughout this article simply because, to date, it remains the dominant label used to describe people in formalized care relationships with health professionals.

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