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Self-determination Theory: A Framework for Enhancing Patient-centered Care

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ABSTRACT

The purpose of this report is to highlight the relevance of self-determination theory (SDT) as a framework for conceiving of and implementing patient-centered care within the United States Army Medical Department (AMEDD). Traditionally, patient-practitioner communication within AMEDD settings has involved directive and hierarchical presentation of information. Consequently, the aim of this report is to examine research suggesting the value of SDT constructs in promoting patient-centered care in AMEDD settings. We have included a brief review of research on patient-centered care and health outcomes and a discussion of SDT principles and SDT-based strategies for promoting patient-centered care.

Keywords: Army Medical Department, patient-centered care, patient-centered medical home, self-determination theory

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The United States Army Medical Department (AMEDD) is responsible for providing health care to service members, their families, and retirees while also maintaining military readiness. In recent years, the AMEDD has transformed from a health care system to a system for health that focuses on improving the delivery of high quality and cost-effective primary care services.[1,2] Similar to the civilian health care system, the AMEDD has embraced the patient-centered medical home (PCMH). As its name suggests, this health care model emphasizes a patient-centered approach to the delivery of health care services, as well as patient empowerment, to maximize health outcomes and to control costs.[3]

Central to the notion of patient-centered care is the relationship between the entire care team and the patient. It recognizes patients' unique health care needs within the context of their culture and values.[4] More importantly, patient-centered care creates an environment that not only supports patients in the autonomous management of their own care, but also includes the family unit in health care decisions. Although notions of patient-centered care have received attention in civilian health care settings,[5] its implementation within the AMEDD is recent.[6] In fact, notions of autonomy may be antithetical to traditional modes of AMEDD health care communication involving directive and hierarchical presentation of information. Within the AMEDD, both civilian and military health care providers deliver care to service members. However, unlike civilian providers, military providers also possess a rank (eg, captain or major) in addition to their actual provider role, and rank designates one's position and authority over others.[7] Therefore, military rank affects the dynamics of the provider-patient relationship. Furthermore, given the sheer size of the AMEDD operating budget ($12 billion) and the vast number of individuals receiving treatment within this system (3.86 million beneficiaries per year), the quality of care patients receive in this context is of evident importance.

Taking into account the specific contextual features of the AMEDD health care settings it seems worth highlighting a framework by which AMEDD practitioners can incorporate evidence-based patient-centered strategies into their clinical practice. The purpose of this report is threefold. First, we examine research assessing the relationships between patient-centered care and salient patient outcomes, such as rehabilitation adherence, perceived disability levels, and patient well-being. Second, given the research findings, we suggest that self-determination theory (SDT) may be an appropriate theoretical framework for conceiving of and implementing patient-centered

care within the PCMH model. Third, and finally, we provide practical suggestions for implementing SDT-based strategies for enhancing patient-centered care. Using an SDT framework could lead to more positive patient-practitioner interactions and enhance patient adherence, whether it be with a rehabilitation program, medication use, exercise, or diet. It is important to note that our intent in this report is not to suggest that SDT constructs are uniquely relevant in AMEDD settings; certainly they have demonstrated applicability in civilian health care settings.[5] Rather, as indicated previously, SDT constructs may be especially important to emphasize in a context traditionally employing more directive and hierarchical forms of health care communication and one that services so many individuals.

RESEARCH ON PATIENT-CENTERED CARE AND HEALTH OUTCOMES

Research on patient-centered care suggests that health outcomes are optimized when health practitioners support patient autonomy (perceptions of volition or self-endorsement of health behaviors), perceptions of competence (a sense of proficiency, or efficacy in initiating and maintaining behavior change), and a sense of connection (relatedness) with health providers.[5] With regard to patient autonomy, it has been found that autonomy-supportive environments predict greater adherence to rehabilitation programs[8,9] and diet regimens,[10] as well as perceived disability.[11] For example, Chan et al.[12] found that autonomy-supportive behaviors exhibited by physiotherapists positively predicted autonomous treatment motivation ($\beta = 0.22$, $P < .05$) among 115 patients undergoing rehabilitation after anterior cruciate ligament reconstruction surgery. Furthermore, rehabilitation adherence ($R^2 = .28$) was positively predicted by autonomous motivation ($\beta = 0.64$, $P < .05$) and negatively predicted by controlled motivation ($\beta = -0.28$, $P < .05$).

It has also been found that patient involvement in treatment decisions—a key characteristic of an autonomy-supportive environment—increases the likelihood of treatment adherence,[9] and that autonomous motivations for undertaking low back pain physical therapy (PT) predict patient disability after PT ($\beta = -4.028$, $t = -2.226$, $P = .035$, $R^2 = .196$).[11] The latter result indicates that, as autonomous motivation for PT increases perceptions of disability decrease. In addition, autonomy-supportive behavioral interventions have proven effective at assisting women with long-term weight loss and weight control,[13] an important consideration given the prevalence of overweight and obesity and the resultant premature mortality.[14]

In addition to the importance of autonomy, fostering patient perceptions of competence and a sense of connection with health care providers has been shown to be pivotal in nurturing patient-centered care and clinical outcomes.[5,15] Williams et al.[15] found that a patient-centered, computer-assisted intervention was effective in improving diabetes self-management outcomes (glycemic control, ratio of total to high-density lipoprotein cholesterol, diabetes distress, and depressive symptoms), partly because it increased patients' perception that their autonomy was supported, which in turn changed perceived competence.

Similarly, Podlog and colleagues[16] found that, among competitive injured athletes, perceptions of competence in completing rehabilitation tasks predicted positive affect, which in turn predicted enhanced return-to-sport outcomes. Moreover, satisfaction of injured athletes' need for connection to significant-others (athletic trainers, coaches) facilitated greater self-esteem and vitality, and diminished athletes' level of concern upon return to play. Finally, Rahman and colleagues[17] found that improvements in competence and feeling connected with rehabilitation specialists predicted improvements in patient well-being among 389 individuals undergoing cardiac rehabilitation. Collectively, these studies highlight the importance of fostering patient perceptions of competence and connection with health providers in enhancing indices of mental and physical health in rehabilitation and health care settings.[16,18]

A SELF-DETERMINATION FRAMEWORK FOR ENHANCING PATIENT-CENTERED CARE

One theory that focuses specifically on the importance of autonomy, competence, and