

was being forced to participate more than preferred which was divided into the main attributes: being forced to take responsibility; being forced to take decision; and being forced to comply and co-operate.

CONCLUSION

Conducting the present analysis from a person-centred framework yielded the novel result, not documented in previous analyses, that not all PP is perceived as person-centred but can be characterised by communicational struggles with HCPs who either do not allow patients as much participation they prefer or force them into unwanted participation. Perhaps this lacuna in the previous analyses can be traced to the fact that patients have not been asked direct questions that could identify constrained PP, such as: ‘Have you participated less/more in your health care than you would have preferred?’ In any case, the attributes of constrained PP identified above must be regarded as a novelty in the literature. The illumination of constrained PP also raises the critical question if HCPs, in some instances at least, are acting in accordance with the implicit paternalistic assumption that it is in patients’ best interest that HCPs determine to what extent patients should participate in their own care, regardless of the patients’ preferences and wishes for participation. A paradox may lurk here: In order to satisfy the demands of anti-paternalism, some HCPs may see it as their moral duty to, so to speak, ‘force patients to be free’. However, such a radical form of anti-paternalism may itself wind up as being paternalistic and disrespectful.

REFERENCES

- [1] K. Thórarinsdóttir and K. Kristjánsson, “Patients’ perspectives on person-centred participation in health care: A framework analysis,” *Nurs Eth*, vol, 21, pp. 129-147, Marz, 2014.
- [2] A.C. Eldh, I. Ekman and M. Ehnfors, “Considering patient non-participation in health care. *Health Expect*,” vol, 11, pp. 263-271, 2008.