

FAST FACT AND CONCEPTS #439
UNDUE INFLUENCE VS RELATIONAL AUTONOMY IN CLINICAL DECISION-MAKING
Timothy Fuller, MD, John Hendrick, MD, Anna C Beck MD

Background: The arrival of a long-absent relative requesting a seriously ill patient pursue interventions of questionable efficacy is practically a cliché in inpatient care (1). It also invites closer evaluation of the role of *undue influence* and *interpersonal decision-making* (1). *Undue influence* is a term used in the published medical literature to describe a family or community member who intentionally or unintentionally influences a patient to choose a treatment plan the patient does not truly desire (2). It can be a source of emotional discord amongst family members, the patient, and the clinical team.

Interpersonal decisional making (also referred to as *relational autonomy*) describes how most seriously ill patients do not utilize solely their own care preferences, but also factor in the care preferences of their loved ones in clinical decision-making (3,4). Often it can be unrealistic to disentangle undue influence and interpersonal decision-making. This *Fast Fact* reviews published opinions from bioethicists, social workers, and others for recognizing and addressing undue influence in those with serious illness.

Clinical clues: Determining whether undue influence is affecting patient care is difficult since there are no diagnostic criteria. The following may suggest undue influence is playing a role (2,5,6):

- A sudden change in or patient's goals of care or care preferences after a family visit.
- Visible patient anxiety when discussing a specific family member or new treatment plan.
- Family member(s) who speak for a patient or talks over a patient even though the patient has capacity to speak autonomously for him or herself.
- Family member(s) who attempt to override the patient's expressed care preferences or threaten to remove financial or other types of support if the patient does not modify their care preferences.

Risk Factors: The following risk factors have been cited for undue influence (7).

- Social/environmental: dependency, isolation, family conflict, recent bereavement.
- Clinical: disability, personality disorder, substance abuse, depression, dementia, or delirium.
- Legal: unnatural provisions in a financial will or advanced directive; financial incentives misaligned with decision making; past abuse, neglect, or coercion of the patient.

Interpersonal decision-making (or relational autonomy): While there are no formal definitions for these terms, most medical publications draw from philosophical and feminist sources to describe how patients define their basic value commitments not just on their own personal desires, but in terms of their relationships and mutual dependencies (4,8,9). In other words, all humans are a part of a complex social network, and our decisions are influenced by roles, relationships, and responsibilities within this network. Additionally, there is a wide variance between cultures, communities, and individual families regarding one's individual role in clinical decision making (10). As clinicians, it is important to avoid rash judgements and recognize our limited perspective of the patient's relationships and how they interact with their illness and cultural context. Patients are at liberty to defer to others even when their own desires might seem at odds. This can be an autonomous decision, reflecting the full balance of their priorities. For example, a dying patient may determine that for their children to appropriately grieve, they must feel that all treatment options had been exhausted and thereby pursue a risky cancer treatment.

Addressing suspected undue influence: Navigating undue influence vs interpersonal decision-making, cultural differences, and strong emotional responses to a serious illness (e.g., guilt, anticipatory grief) can be very challenging. Some experts advocate that clinicians consider themselves as part of a clinical decision-making *triad* (not dyad) involving the patient and their loved ones in which the clinician role is to constructively reframe the balance toward the patient (11). While there are no published guidelines on how to do this, the following have been suggested in the published medical literature (2,5,6):

- Speak with clinicians (e.g., social workers, PCPs) who know the patient well. Are the patient's care preferences consistent? Have others witnessed concerning family dynamics or issues?
- Utilize an interdisciplinary team to explore the multi-dimensional perspectives of the triad.

- Speak with the patient, ideally, in private, regarding your concerns utilizing open-ended questions to explore their hopes, expectations, and care values. Clarify how the patient would triage if conflicting care preferences were expressed by others.
- Speak with the family member(s) (or friend) to better understand motives and reasoning.
- Facilitate a serious illness discussion: this provides a context for open communication about prognosis and goals of care while offering an opportunity for real-time negotiation among the triad.
 - Encourage participants to make their motives and concerns for the patient transparent so that the understanding of all viewpoints can be best facilitated.
 - Explore any emotions underlying the care perspectives of the patient and family.
 - If the patient is unable to make medical decisions due to delirium, dementia, etc., ask others to consider treatment options through the lens of the patient's substituted judgement: "*If (the patient) was in the room right now, what would they say...*"
 - Bring a copy of the patient's advance directive (if available) to review with the family; particularly if an incapacitated patient has outlined specific care preferences.
- Empower the patient: remind the patient that if their care goals are informed and medically reasonable, they are at liberty to choose. Routinely assess their comfort with the plan of care.

References:

- 1) Volandes AE, The Conversation : A Revolutionary Plan for End-of-life Care. First U.S. ed. New York, New York: Bloomsbury Publishing; 2015.
- 2) Baker FX, Gallagher CM. Identifying and Managing Undue Influence From Family Members in End-of-Life Decisions for Patients With Advanced Cancer. J Oncol Pract. 2017 Oct;13(10):e857-e862. doi: 10.1200/JOP.2017.020792. Epub 2017 Aug 22. PubMed PMID: 28829694.
- 3) Zhang AY, Siminoff LA. The role of the family in treatment decision making by patients with cancer. Oncol Nurs Forum. 2003 Nov-Dec;30(6):1022-8. doi: 10.1188/03.ONF.1022-1028. PubMed PMID: 14603359.
- 4) Walter JK, Ross LF. Relational autonomy: moving beyond the limits of isolated individualism. Pediatrics. 2014 Feb;133 Suppl 1:S16-23. doi: 10.1542/peds.2013-3608D. PubMed PMID: 24488536.
- 5) Sedig L. What's the Role of Autonomy in Patient- and Family- Family Members Don't Agree?. AMA J Ethics. 2016 Jan 1;18(1):12-7. doi: 10.1001/journalofethics.2016.18.1.ecas2-1601. PubMed PMID: 26854631.
- 6) Ho A. Relational autonomy or undue pressure? Family's role in medical decision-making. Scand J Caring Sci. 2008 Mar;22(1):128-35. doi: 10.1111/j.1471-6712.2007.00561.x. Review. PubMed PMID: 18269432.
- 7) C. Peisah, S. Finkel, et. Al. The Wills of Older People: Risk Factors for Undue Influence. International Psychogeriatrics. 2009, 7-15. Vol 21, Iss. 1. doi: <https://doi.org/10.1017/S1041610208008120>
- 8) Gómez-Virseda, C., de Maeseneer, Y. & Gastmans, C. Relational autonomy: what does it mean and how is it used in end-of-life care? A systematic review of argument-based ethics literature. BMC Med Ethics 20, 76 (2019). <https://doi.org/10.1186/s12910-019-0417-3>
- 9) Christman, J. (2004). Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves. Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition, 117(1/2), 143–164. <http://www.jstor.org/stable/4321441>
- 10) Julie W. Childers, Robert Arnold, "She's Not Ready to Give Up Yet!": When a Family Member Overrides the Patient's Medical Decisions, Journal of Pain and Symptom Management, Volume 62, Issue 3, 2021, Pages 657-661, ISSN 0885-3924.
- 11) Tulsy JA, et al. Triadic agreement about advanced cancer treatment decisions: perceptions among patients, families, and oncologists. Patient Education and Counseling 2021 <https://doi.org/10.1016/j.pec.2021.08.001>

Author Affiliations: University of Utah, Salt Lake City UT

Conflicts of Interest: None to report

Version History: Originally edited by Sean Marks MD; first electronically published in February 2022

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's*

content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

Copyright: All *Fast Facts and Concepts* are published under a Creative Commons Attribution-NonCommercial 4.0 International Copyright (<http://creativecommons.org/licenses/by-nc/4.0/>). *Fast Facts* can only be copied and distributed for non-commercial, educational purposes. If you adapt or distribute a *Fast Fact*, let us know!

Disclaimer: *Fast Facts and Concepts* provide educational information for health care professionals. This information is not medical advice. *Fast Facts* are not continually updated, and new safety information may emerge after a *Fast Fact* is published. Health care providers should always exercise their own independent clinical judgment and consult other relevant and up-to-date experts and resources. Some *Fast Facts* cite the use of a product in a dosage, for an indication, or in a manner other than that recommended in the product labeling. Accordingly, the official prescribing information should be consulted before any such product is used.