



Response to Professor Anderson's commentary on Empowerment article by Asimakopoulou, K

Sir, We read with interest Professor Anderson's commentary¹ on the paper by Asimakopoulou, on the assumptions underlying the concept of empowerment.² The commentary highlighted the agreement between authors around the notion that empowerment is a long-term, ongoing, work-in-progress and that the traditional medical model still presents barriers to health care professionals (HCPs) adopting the 'new paradigm'. The key assumption of the empowerment approach is that the traditional medical model created passive patients and that these patients need to be 'activated' to care for themselves. One of the key assertions of the empowerment assumptions paper was the appropriateness of adopting the empowerment approach with those unwilling or unable to participate or be activated, in this sense. Hence, the empowerment assumptions paper was noting implicitly that the traditional medical model, *vis à vis* the adoption of the empowerment approach, also entails a new paradigm for the patient throughout the entire medical encounter, particularly around care planning and the negotiation of roles and responsibilities in managing illness.²

Professor Anderson argued that patients are empowered through 'patient-centred care', '...providing patients with what they want and need. We encourage patients to tell us about aspects of the self-management plan that did not fit well with their lifestyle and we view discussion of possible revisions as collaborative care'.¹

Leaving aside socio-economic differentials, asymmetries of information in the relationship and the

potential for temporal and spatial constraints on the interaction (all of which are implicit in the assumption of the need for, and utility of, the empowerment approach), concerns can still be raised around how issues are framed by HCPs, particularly in the context of those who can influence health outcomes, and the way that options are arrived at and selected. In this sense, the patient is afforded the choice as to how much they wish to participate in their own care (as noted by both papers), however the degree of participation in this process is often conflated with the actual choices or options made available to patients by their HCP.

Thus, we would argue that the empowerment paradigm shift often uses the flaws of the traditional medical model as an analytical crutch with which to illustrate the benefits of the empowerment approach. Inherent in this notion is the assumption that the key features of empowerment – patient-centring and collaborative care – can be *neutrally* negotiated to allow information to be shared between HCP and patients, allowing them to make informed decisions and be equal partners in care. However, throughout the process, patients' choices are selected and promoted in light of the constraints acting on the HCP.

Finally, the point made in the original article remains. Just because a process is new and (allegedly) more appropriate than the models it has replaced, it does not mean that it should not be monitored, or its success in being implemented not assessed. Until HCPs and patients have agreed on some observable, testable, formal

criteria aimed to check that an empowerment process in diabetes is taking place *and* meets some observable outcome within diverse cultural settings, our view remains that caution should be exercised in any claims made about having acted in an empowering manner. In fact, this monitoring and evaluation will go some way to allowing the more fundamental assumptions to be isolated, tested and (if necessary) amended.

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References

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2. Asimakopoulou KG. Empowerment in the self-management of diabetes: are we ready to test assumptions? *Eur Diabetes Nursing* 2007; **4**: 94–97.

Letters

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