

Achieving shared understanding in chronic care interactions: the role of caregivers

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Abstract

Purpose – *Within the context of a research program on the most relevant discourse types in chronic care medical encounters, this contribution reports on a qualitative study on the role caregivers play within the process of shared understanding occurring between health-care professionals and elderly patients. The purpose of the paper is to highlight one dimension of such complexity, by bringing to light the challenges connected to the achievement of shared understanding between health-care professionals and elderly patients when caregivers are involved in the conversation.*

Design/methodology/approach – *The paper reports on a two-step analysis of a corpus of transcripts of interactions in diabetes and hypertension settings. In the first step, caregivers' contributions to deliberative sequences have been analyzed. In the second step, the analysis was extended to caregivers' contributions to the whole encounter.*

Findings – *The results show that professionals' ability to engage caregivers in deliberations during the encounter and, more generally, to assign a role to caregivers as legitimate participants in the consultation may favor the smooth development of the interaction and an effective process of shared understanding among all participants.*

Originality/value – *The paper further develops original research about the functions of the argumentative component in dialogues occurring in clinical settings.*

Keywords Activity types, Discourse types, Deliberation, Decision-making, Doctor-patient interactions, Caregivers, Elderly patients

Paper type Research paper

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1. Introduction

The dialogical interaction between clinicians and patients in the context of chronic care is a particular institutional setting that presents many aspects of interest for scholars exploring the complexities of verbal interactions. The main characteristic of chronic care that makes it an interesting field of inquiry for dialogue scholars is the fact that, when faced with chronic diseases, clinicians cannot rely merely on drugs and medical treatments to obtain better health. Patients need to be actively involved in their own care, they need to be ready to change their lifestyles to accommodate the new needs imposed on them by their disease and to do this they need to be motivated. This presupposes that they have been informed about the risks they run if they do not cooperate and about the basics regarding the functioning of their disease. It also means that clinicians need to continuously motivate their patients and support their determination in the long run. An additional challenge regard the fact that patients' life conditions may change over time and clinicians need to be always alert about this and ready to renegotiate the terms of their requirements for patients to be able to comply also in their new life situation (on chronic care, among others: [Wagner et al., 2001](#); [Coleman et al., 2009](#); [Osborn et al., 2015](#)). Clearly, all these issues can only be addressed by means of adequate communication skills.

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In particular, when considering elderly patients' needs, the analysis of medical encounters becomes even more complex and interesting. Indeed, on top of the difficulties related to old age, in many cases, elderly patients are accompanied by their caregivers, who might be members of the family (spouse, relevant other, children, grandchildren, etc.) or persons paid to live with them and look after them. In all of these cases, an already complex interaction is made even more challenging by the presence of a third party, who is not always helpful, as will be shown.

The literature on communication skills in healthcare is vast and highly multidisciplinary; the focus of this paper is on chronic care encounters, viewed as dialogue types essentially aimed at advice seeking, featuring advice-giving as the most relevant discourse type (Bigi, 2018b). One of the components of advice-giving as a dialogical process is deliberation, which is typically realized through argumentative discourse (Locher and Limberg, 2012; Bigi, 2018b). Thus, one goal of the paper is to observe what kind of contributions caregivers give to deliberative sequences within medical encounters.

One interesting aspect of the use of argumentative discourse in medical encounters is that it can be an effective tool to achieve a shared understanding of the assessment criteria that are used to make decisions (Bigi, 2018a). This is an important, albeit less researched, aspect of interactions in medical settings, as shared understanding can actually be assumed to be a precondition for effective, participatory care: indeed if the parties involved in the encounter are not able to share their understanding of the disease, of its symptoms and of its treatment, it will be very difficult to achieve the goals of patient motivation and support mentioned above. Therefore, another goal of the paper is to discuss the role elderly patients' caregivers may have in the process of shared understanding that is developed throughout the whole interaction [1].

1.1 Shared understanding and argumentative discourse

Medical encounters in general and chronic care encounters, in particular, are characterized dialogically by high complexity, due to the need for participants to achieve many different goals, which require them to shift among different types of dialogue within a single interaction [2]. This may actually happen also in other interactional contexts, but factors such as social disparity, the institutional nature of the interaction, the frailty connected to sickness or old age, may contribute to making the complexity of dialogues in medical settings much more challenging than dialogues in other settings. A particularly difficult type of dialogue, which is also very important for the achievement of decision-making in medical encounters, is the deliberation dialogue (Walton *et al.*, 2014; Bigi, 2016). This is the kind of dialogue parties use when trying to agree on a course of action in view of solving a problem. Its complexity derives from the fact that it combines an information-seeking component with a persuasive one: to make sound decisions, parties need to share relevant information, put forward proposals for action based on this information and argue in favor or against these proposals. In so doing, new information might come up, calling for a revision of the facts and a redefinition of the proposals; etc., until a course of action is identified that everybody agrees with and can be accepted.

It is in particular during this process of revision of the facts and redefinition of proposals that parties are forced to use argumentative strategies to make explicit the reasons for preferring certain solutions instead of others.

If developed effectively, this dialogical process can lead parties to achieve a shared understanding of the problem at issue or an alignment regarding the criteria for the interpretation of the facts under discussion (Asterhan and Schwartz, 2009; Bigi, 2018a). In the reality of medical encounters, this result is seldom observed, but it would be a very important achievement as it actually corresponds to the realization of patient-centeredness

in its most concrete sense, i.e. taking into consideration patients' perspectives and integrating them into the discussion and into the problem-solving process.

In the context of elderly patients' care, eliciting the reasons for patients' resistance or non-adherence to therapies or healthy behaviors would be a crucial step toward the ideal of patient empowerment and engagement (Barello and Graffigna, 2014). However, as mentioned above, the achievement of this goal is complicated by a number of factors, not least by the presence of patients' caregivers.

By addressing the wider question of which factors can hinder or facilitate the process of alignment and shared understanding between health-care professionals and patients, this paper is focused in particular on a more specific question: in chronic care interactions, what happens to this process of shared understanding when more parties are involved? In particular, how do elderly patients' caregivers contribute to this process? Is there a "dialogical role" for them? Are their contributions facilitating or hindering the achievement of shared understanding?

2. Materials and method

To answer the questions above, the study was conducted in two steps. In the first step, an analysis of caregivers' contributions to deliberative sequences was performed. In the second step, the analysis considered caregivers' contributions to the whole encounter.

2.1 First step: Caregivers in deliberation

The analysis was conducted on a corpus of transcripts of 53 video recordings of interactions collected in an Italian diabetes outpatient clinic (Bigi, 2014).

In total, 13 of these interactions, patients were accompanied by family members. These cases were analyzed as cases of medical encounters with potential caregivers. The status of "caregiver" was assigned to those persons accompanying patients who appeared to be either those who lived with the patients and supported their effective self-care behaviors or those who contributed to patients' effective self-care behaviors even without living with them. Elderly patients are identified as persons who are older than 65, which was the case for all the encounters collected in the corpus.

In the proposed analysis, caregivers' contributions to deliberative sequences were taken into consideration and assessed based on their relevance for the deliberative aim of the sequence. The *dialogical relevance* of individual moves is defined in relation to the "macro-interpretation" of the type of activity the interlocutors are engaging in and the generic purpose they are pursuing (Van Dijk, 1977; Macagno and Bigi, 2017). In other words, relevant dialogue moves allow the correct interpretation of interlocutors' dialogical intentions.

2.2 Second step: Caregivers in the whole encounter

To observe caregivers' contributions in different clinical settings and overcome potential bias deriving from the specific characteristics of a single clinical setting, the second step of the analysis adds to the corpus was made. The analysis was conducted on the same corpus used for the first part of the study and, in addition, on 9 interactions taken from the Archive of Video-recordings of Medical Consultations, collected and maintained at San Paolo Hospital in Milan [3]. Of these nine interactions, five were collected in a general practice setting, while four in a hypertension clinic. Also in all these cases, patients were older than 65 and they were accompanied by their spouses. In this second part of the analysis, caregivers' contributions have been analyzed by considering discourse roles and acting roles. As argued in Halvorsen and Sarangi (2015), when participant roles are observed at the utterance level, they can be called "discourse roles" and they express the

relationship between participants and the message. On the other hand, when participant roles are observed at the level of the speech event, they can be called “activity roles” and they express the relationship between the participants and the activity type (e.g. meeting chair, meeting member, etc.).

3. Results

The results of the analysis are presented separately and then discussed.

3.1 *Caregivers' contributions to deliberation*

For this part of the analysis, 13 encounters were selected from the corpus. In these encounters, 18 deliberative sequences have been found. Caregivers' contributions to these sequences have been found to be of different types; examples for each type can be found in [Table 1](#). In some cases, caregivers simply provide information: they fill in when patients forget something or they specify information given by patients. In other cases, caregivers ask questions that can be requested for explanations or requests of information (in general, with the intention of helping patients being more adherent to therapies or dieting). Proposals for action by caregivers during deliberation sequences were very rare. In some cases, dialogically construct for themselves the role of “vice-doctor,” but taking a critical attitude toward patients. In general, there are collaborative caregivers who put forward proposals, fill in the information, try to understand; and there are fewer collaborative caregivers who take the floor, shift the attention of doctors to irrelevant topics, speak about themselves or let patients feel inadequate.

Overall, contributions to deliberation are not the majority of caregivers' contributions to consultations.

3.2 *Caregivers' contributions to the whole encounter*

The finding that caregivers were not contributing so much to the deliberation phases of encounters, triggered the second step of the analysis. If they were not participating in the decision-making phases, were they contributing more to other parts of the consultation? If yes, how?

To answer this question, the analysis focused on the roles caregivers play as participants in the interaction. In general, the predefined activity roles in a medical encounter are those of “doctor” [\[4\]](#) and “patient.” Is there an acting role for the caregiver?

As for discourse roles, two kinds can be described: production and reception roles. Based on the characterization of the chronic care encounter, as described in the introductory section of this paper, in a production role, individuals may play the part of “Advice giver,” “Information giver,” “Assessor” and “Elicitor”; in a reception role, instead, individuals may play the part of “Addressee” (targeted listener, therefore, has listening obligations) or of “Audience” (not targeted listener, therefore, has partial listening obligations). It is the topical focus that determines who is “Addressee” or “Audience” at any given interactional moment ([Halvorsen and Sarangi, 2015](#), p. 5).

Based on the observation of the ways in which caregivers contribute to the conversations, it does not look like caregivers have a well-defined activity role; this implies that they have no clear commitments, there are no clear expectations about their contributions and there is no clear pattern (when, what, how) for their contributions. Indeed, in the corpus caregivers can be legitimized by doctor or patient; but sometimes, they contribute without explicit legitimization.

Table 1 Caregivers' contribution to deliberation sequences (in both tables, examples have been translated by the author from Italian)

Types of contributions by caregivers to deliberation sequences

Examples from corpus

- Provide information	- Fill in: DOCTOR: What do you have for breakfast? Coffee with milk and two slices of rusk . . . PATIENT: Two slices of rusk DOCTOR: . . . or biscotti? PATIENT: No, two slices of rusk, toasted bread DOCTOR: Ah! that's a different thing, toasted bread WIFE: No, it's not toasted, it's those slices of bread that you can toast but we don't toast it - Specify: DOCTOR: any physical activity? PATIENT: well, we walk a bit HUSBAND: a bit, a bit, now she's doing a bit DOCTOR: you do it or very little? PATIENT: yes, we only go walking HUSBAND: we go walking in the park
- Request explanations	DOCTOR: . . . then you wait six or seven days and you record your evening glucose values again PATIENT: in the evening, ok DOCTOR: then you wait six or seven days . . . ok? DAUGHTER: more or less always one week? DOCTOR: yes, well, wait I would like to explain to you, it's not so much one week that matters . . .
- Request information	PATIENT: so I can take this? Can I take this one normally? DOCTOR: so, they give it as an alternate to [NAME OF PILLS] WIFE: but is it the same thing? DOCTOR: it's the same
- "Vice doctor," critical attitude	DOCTOR: you were 77 kilos, now you are 76, I would like a 70. So maybe we can take this year to . . . PATIENT: ok DOCTOR: . . . ok? This year and we try by the end of the year, beginning of the next to get there PATIENT: all right DAUGHTER: yes, but not in the sense that if it's in one year to start dieting the past three months (Daughter: "quindi deve farlo la mattina e la sera? Dopo cena?" . . . "no così lo so anch'io e la controllo" (P_2-2))
- Shift to an irrelevant topic	PATIENT: I have to look after my grandchildren, one is 1 the other is 1 and a half . . . yeah, well, with them I do move around a lot, but . . . DOCTOR: but probably it's not the same . . . PATIENT: Yeah, it's not the same I was doing before HUSBAND: walking . . . I go walking too

Caregivers' contributions are of at least four types; examples are shown in [Table 2](#). They appear as "Assessor" or "Advice giver": in these cases, caregivers dialogically construct for themselves the role of the "vice-doctor," often adopting a critical attitude toward the patient. They appear as "Information givers," when they fill in for patients or when they provide details patients may have forgotten. In some cases, they take the role of "Addressee" and this can be done in different ways: they can be seen improperly responding to questions in the place of patients; simultaneously responding with patients; or, they can be legitimized "Addressees" because doctors feel they should be giving their instructions to them, if, for example, patients are not fully capable of understanding. Finally, there are a few cases in which caregivers perform non-relevant dialogue moves, shifting to other dialogue types (e.g. from information giving to chat), not always in a collaborative way.

Table 2 Caregivers' contributions to the whole encounter

<i>Caregivers' activity roles</i>	<i>Types of contributions by caregivers to the whole encounter</i>	<i>Examples</i>
Assessor/advice-giver	- Act as "vice-doctor"	DOCTOR: explains that it is important for the patient to get back to a careful dietary regimen PATIENT: yes yes, I know, but honestly when you're not feeling well, like this past period . . . DAUGHTER: yes, but mom, you have to take care of yourself. I went to the seaside with her, right, I mean, she ate ice cream, right? I mean, we had arguments, big arguments, I told her, if I had diabetes, this ice cream, even if it's just a little, I wouldn't eat it. I'm telling you, honestly . . . DOCTOR: your exams are really very good HUSBAND [standing behind patient]: see, that's what I keep telling her . . .
Information giver	- Fill in the information	PATIENT: I have a cough WIFE: he's driving me crazy, with my hearing aid DOCTOR: When did it begin? WIFE: at the beginning of the week DOCTOR: Was it the same then or less? WIFE: a bit less
Addressee	- Respond in the place of or with patients - Are legitimized, addressees	DOCTOR: so, how are you? PATIENT: I have problems when I go to the bathroom [WIFE overlaps but words are not clear] DOCTOR: do you have diarrhea? PATIENT: no no/WIFE: I don't know [simultaneous answer] DOCTOR: Are you following a diet for your diabetes? PATIENT: [to wife] you speak . . .

3.3 Discussion of results

The study presented in this paper aimed at addressing the question regarding the kind of contribution elderly patients' caregivers give to medical consultations, in particular to the process of shared understanding that is so important for patients to be actively engaged in the development and maintaining of their well-being. More specifically, the aim was to understand if and how caregivers contribute to the deliberation sequences in consultations; and if and how caregivers contribute to the consultations overall.

In the first part of the study, from the analysis conducted on a small corpus of consultations collected in a diabetes outpatient clinic, it appears that caregivers do not contribute so much to the deliberation sequences. When they do so, it is more to provide or specify information than to put forward proposals for action.

As for the second part of the study, the analysis of participants' roles suggests that caregivers' non-relevant or non-collaborative contributions may be due to lack of clarity as to their activity role and, as a consequence, also of their discourse roles. Especially when they construct for themselves the role of "vice-doctor," this is seldom done in a constructive way. More often, they use this role to show reproachful or blaming attitudes toward the patients. Could it be they are feeling guilty for not being able to help patients more? Or could this be some kind of face-saving strategy? The fact is that this kind of role often seems to get in the way of doctors' efforts at rapport building, as they are sometimes drawn into the confrontational atmosphere constructed dialogically by the caregivers.

As [Halvorsen and Sarangi \(2015\)](#) observe:

"By adopting or assigning particular discourse roles, participants implicitly make claims about their role positioning and relationships with co-participants and at the same time redefine or reframe the activity in which they engage" ([Halvorsen and Sarangi, 2015](#), p. 2).

Indeed, the consultations in which caregivers assigned to themselves roles that were not aligned with the goal of the dialogue type ended up being much more difficult than those in which all roles were clear from the start.

4. Concluding remarks

The chronic care medical encounter is a highly complex dialogical activity, as parties need to shift between different dialogue types to achieve their institutional goals. The need for these shifts is not always obvious to all parties in the same way, nor is it obvious *which* dialogue types are more relevant than others in the specific situation. The shared understanding process that needs to take place over the course of time can be favored by effective use of argumentative practices, which can be used both to deliberate and to achieve alignment in the interpretation of symptoms. If clinicians are aware of argumentation as a dialogical activity and are able to guide argumentative sequences, this may create a favorable environment for shared understanding and participatory care (without clinicians giving the impression that they are surrendering their professional role, [Dingwall and Pilnick, 2020](#)). Another element that may favor shared understanding (and, as a consequence, patient motivation and adherence) is the collaborative and constructive participation of caregivers in the encounter: this style of participation seems to be hindered when caregivers are not sure about their activity role. Legitimizing caregivers and sharing the agenda with them at the beginning of the encounter could be a strategy to favor their participation, at the same time avoiding the downsides of caregivers' interference with clinicians' rapport building aimed at patients. More empirical research could provide specific interactional cues of caregivers' perception of their role within the encounter, thus providing clinicians with practical elements to prevent or solve caregivers' distress at not finding a role for themselves in the consultation.

Notes

1. The analyzes reported in this paper have been presented during two conferences: the CLAVIER Conference, held in December 2018 at IULM University, in Milan (Italy); and the Age.Vol.A. Conference, held in April 2019 at Università dell'Insubria, in Varese (Italy). I thank the participants to the conference panels for precious feedback that has helped the redaction of this paper.
2. In this paper, the concept of "dialogue type" is used according to the definition given by [Walton and Krabbe \(1995\)](#).
3. A special because of Prof. Elena Vegni and her team, for allowing me access to the archive and providing support when needed.
4. For simplicity, the term "doctor" is used to include all types of healthcare professionals.

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