Elderly patients constitute a **vulnerable group** because of age and specific disease conditions (e.g. Dementia, Alzheimer’s, Aphasia, Huntington’s disease) with reduced cognitive capabilities.

More generally, the elderly population are [made] **communicatively vulnerable** in their encounters with professional carers in clinics, hospitals, nursing homes – and even in domestic settings.

This requires carers (healthcare professionals and relatives) to assume ‘**communicative responsibility**’/‘**adaptability**’ in engendering patient involvement and participation in shared decision making.
Different framings of communication:

- **Communication as common sense:** communication as the mundane, natural, cultural construct that everybody is a competent communicator (like a native speaker, even though one may not be able to explain how the language system works using a metalanguage)

- **Communication as skill/behaviour**

- **Communication as art**

- **Communication as science/knowledge:** communication as a scientific discipline with theories/principles underlying how we communicate.
• Communication as system (made up of sub-systems) and as environment (Watzlawick et al. 1968)

• A system can be defined as “a set of objects together with relationships between the objects and between their attributes” (Hall and Fagen 1956: 18), in which objects are the components or parts of the system, attributes are the properties of the objects, and relationships “tie the system together”. (cited in Watzlawick et al 1968: 120)

• As a system, communication is both dynamic and ecological – allowing for intervention and adaptation.
SOME SCENARIOS OF COMMUNICATIVE VULNERABILITY INVOLVING OLDER PATIENTS
SOME SELECTED SCENARIOS

- Salter (2010) – as a part of an intervention study, about pharmacists’ medication review of older patients (80+ years of age) in the home setting.

- The focus is on ‘screening and testing’ of older patients’ physical and mental abilities to comply, against the backdrop of non-compliance with prescribed medication regime on discharge from hospital.

- Medication review as preventative healthcare initiated in the UK by the National Health Service (NHS 2001) in response to up to 30% of hospital admissions owing to adverse drug reactions in older patients.
• Older people as long-term users of medicines, but they tend to forget to take their medicines.

• The encounters between pharmacists and the older patients in the home setting were primarily task-oriented, driven by the compliance paradigm – with many awkward interactional moments.

• There were minimal reciprocated discussions from a concordance viewpoint.

• The pharmacists failed to take on the extended role of ‘drug counsellor’, which required a different set of communicative practices.
Lindholm (2008) studies elderly dementia patients’ communicative behaviour in out-of-clinic settings in Finland.

**Use of laughter to manage communication difficulties** – attesting that the social interactional competence of these elderly people is intact despite their dementia status.

Such out-of-clinic settings can be used for carrying out institutional assessments, while enhancing elderly people’s quality of life.
Aaltonen and Laakso (2010) examine aphasic interaction involving non-aphasic partners in Finland, focusing on ‘halts’ – when conversation is on hold because of difficulty in finding words.

‘Real halts’ and ‘exam halts’ have to be balanced in spousal relationships – the ‘exam halts’ function as scaffolding, resembling the educational setting.

Although appearing non-cooperative, the spouses assume communicative responsibility in allowing their aphasic partners to search for words – thus promoting a visible display of a competent self and a sense of accomplishment.
• Goodwin (1995) on aphasic encounters – based on a case study in the USA, where the aphasic person can only use three words: ‘yes’, ‘no’ & ‘and’.

• This required the communicative partners – the wife and the nurse carer – to make interactional adaptation and take responsibility to design questions accordingly which can be responded to by using ‘yes’, ‘no’ & ‘and’ answers as well as intonation and gesture, thus overcoming the aphasic person’s vulnerability.
• Coupland and Coupland (1998, 2000): in geriatric clinics in the UK, patients occupy **third party status** as healthcare professionals and carers communicate directly with each other, bypassing the patient.

• Companions act as self-selected spokespersons, thus the patient is framed as third-party (e.g. use of pronouns) with reduced communicative entitlements (see also Tsai 2005).

• **Inevitable tensions between patient autonomy and the dynamics of multi-party interaction.**

• **Speaking for vs. Speaking with** – the chauffeuring model of medical triads.
HUNTINGTON’S DISEASE MANAGEMENT CLINIC
01 Co: (looking at C1) and if she continues to lose weight, while she’s putting in as much as she can, then it may be that we should be thinking in terms of PEG. We mentioned PEG briefly last time. Have you had any more time to think about it?
02 C1: I haven’t. I had one.
03 Co: While you were in intensive care yeah. Have you told [Researcher’s name] that actually (laughs) these two have been through a lot as a pair really cos you were really quite ill.
04 [Researcher smiles and nods]
05 Co: Ok so you um know what a PEG’s about really.
06 C1: Yeah.
07 Co: That’s very helpful. But we need to think in terms, not at this very minute....but if you continue to lose weight then we may need to think in terms of having a PEG put in. (Looks at P1) Do you understand what a PEG means P1?

08 P1: Yeah.

09 C1: She saw me with mine.

10 Co: Of course she did yeah. You probably know better than I do then. How would you feel about that?

11 P1: I wouldn’t particularly like the idea.

12 Co: You wouldn’t particularly like the idea.

13 P1: No.

14 Co: No I can understand that. But would you be willing to consider it if you continue to lose weight and you feel it’s important?
15 P1: *(Looks at husband)*
16 Co: So I wonder if it may be useful even at this stage to arrange for you to see one of the PEG nurses who can give you a bit more first hand information. It might be helpful.

17 C1: I don’t know I think she saw enough when I had one fitted.
18 Co: Ok right (slight laugh).

[Pause]

19 C1: You know I had one for about three months.
20 Co: Yeah I remember you were quite ill weren’t you.
21 C1: Yeah I was.

[Pause]

22 Co: *Yeah well you certainly don’t have to do that, but um. Do you have any questions? (Looks at D1)*
23 D1: Not really no. Obviously dad had it when he was ill. But I didn’t pay that much attention to it.
24 Co: No.
25 D1: I was concentrating on whether he survived the night. Um no I think honestly you know if mum loses too much weight......

26 C1: **The worst scenario. If the worse came to the worst she’d have to have it.**

27 Co: Yeah, yeah I think that...well it can always be capped off or taken out as you well know. It doesn’t have to be, you don’t have to look at it as something that is irreversible. And it also doesn’t stop you eating which is the other thing. If you have a PEG in place it doesn’t stop you eating whatever you want to eat by mouth. **But the difficult thing is the timing of the decision because it’s a decision that we don’t want too late, you know we don’t want P1 to lose a huge amount of weight cos then she’d be less strong to have the PEG put in.**
Six stages in terms of participation/interaction [Duffin and Sarangi forthcoming]

- Formulation of the problem
- Confirmation/ownership of the problem
- Generation of potential options
- Evaluation of the options
- Formulation of the decision
- Evaluation/adoption of the decision
• The consultant formulates the decision about the peg early on based on her concerns about P’s continuing weight loss. P is referred to in 3\textsuperscript{rd} person, which undermines her participatory role in decision making. Co uses ‘we’ to signal sharedness.

• The carer (C1) responds to the consultant’s (Co) suggestion about the peg not in his capacity as carer – by foregrounding his prior experience with peg (note the use of ‘I’) rather than thinking in terms of what the peg would do for P (control weight loss).
• Having acknowledged C1’s negative experience of peg, Co now orients to P1 directly and asks for a response – especially if she understands what a peg means (not semantically but in terms of life style). Co mitigates the intervention (‘not at this very minute’).

• Following P1’s articulation of dispreference, Co echoes this dispreference which is intended as a request for elaboration/ explanation, but P1 responds with an emphatic ‘no’.

• Co reinforces the decision for peg – moving away from feelings of discomfort towards peg as life-saving intervention.
SHARED DECISION OR DECISION SHARED?

• Co changes tack by suggesting a meeting with Nurse – thus moving the decision making process/participation framework to the next phase and to underscore the importance of peg.

• Co now turns to D1 who is co-present, but silent so far. D1 colludes with Co in stressing P1’s continuing weight loss as a concern.

• Co now considers the peg decision to be a shared one, but interprets C1’s hypothetical extreme case formulation as still dispreferred, so lists the benefits and makes concessions to normalise the intervention (it can’t be seen; it is not irreversible, P1 can still be mouth fed etc.).
PATIENT AUTONOMY VS COMMUNICATION DYNAMICS

Cognitive competence
Informed decision-making
Ability to cope with medication, treatment and management of condition
Independence in living arrangements

Communicative competence
Formulation of agency in multi-party communication setting
The process variable and communicative vulnerability
Towards communicative ecology
SELECTED REFERENCES


