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Aging, uncertainty, and independence: how doctors and patients manage growing old in primary care

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by

Caroline Kim Tietbohl

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ABSTRACT OF THE DISSERTATION

Aging, uncertainty, and independence:
how doctors and patients manage growing old in primary care

by

Caroline Kim Tietbohl
Doctor of Philosophy in Sociology
University of California, Los Angeles, 2020
Professor Stefan Timmermans, Chair

There are two basic assumptions about medical care that both patients and physicians subscribe to upon entering the exam room: 1) that a medical recommendation can be made, and 2) that patients can comply with the recommendations. But in some instances, this is not the case; previous research shows, for example, that adhering to normal guidelines for older patients can actually diminish their quality of care. In this dissertation, I explore what doctors do when the assumptions that drive medical care no longer apply by focusing on one setting where this issue is especially relevant – primary care for older adults. For older patients (defined here as adults aged 65 or older), the absence of these assumptions is linked to negative understandings of old age. Clinicians can feel that treating older patients is futile because often their health problems cannot be cured, leaving providers uncertain about the best clinical course of action and whether the chosen treatment might cause more health problems than it alleviates. Thus, older patients and their doctors must grapple with a few core issues each time they meet: the entanglement of medical and non-medical problems, uncertainty about how to address complex health issues, and whether older patients are independent and reliable enough to carry out the recommended course of action. Using a combination of ethnographic and conversation analytic methods, this dissertation demonstrates how the process of aging – and the problems that are associated with it – are confronted and managed collaboratively in primary care interactions. Chapter 2 begins this examination of aging in interaction by discussing how the stigmatized label of being old is talked about. This chapter shows that although the label of old age is stigmatized, it can be mobilized as an interactional tool that facilitates discussions about uncertainty. Chapter 3 explores how patients demonstrate independence and personal responsibility for their health through strategic question design. Chapter 4 examines instances in which patients' ability to manage their health may be irrelevant because the doctor has no treatment to offer, and that in these situations, doctors can provide empathy.

This dissertation of Caroline Kim Tietbohl is approved.

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CHAPTER 1

PERCEPTIONS OF AGING: HISTORICAL AND METHODOLOGICAL CONSIDERATIONS

1.1. INTRODUCTION

Patients visit the doctor's office for many reasons: a lingering cough, a rash, a vaccination, a heart murmur. Whatever the reason for the visit, there are two basic assumptions about medical care that both patients and physicians subscribe to upon entering the exam room. First, it is assumed that a medical recommendation can be made, and often that there is a clear best practice to guide that recommendation (otherwise, why see the doctor?). Second, it is also assumed that patients are capable of complying with the recommendations they receive. But in some instances – such as treating elderly patients – these assumptions do not always apply because the doctor may not have a clear solution to offer, and the patient may not be fully capable of carrying out the recommendation even if it exists. Previous research shows, for example, that adhering to normal clinical practice guidelines in caring for older patients can actually have detrimental effects and diminish their quality of care (Boyd et al. 2005). Additionally, as experts in the study of aging have noted, "when chronic illness occurs late in life, uncertainty grows as serious questions arise about whether the individual will be able to weather the disruption and go on with daily life" (Becker and Kaufman 1995, p. 166).

In this dissertation, I explore the question of what doctors do when the typical assumptions that drive medical care no longer apply. Although this question may relate to many contexts that involve uncertainty, I will focus on one setting and population where this issue is especially salient – primary care for older adults. For older patients (defined here as adults who are aged 65 or older), the absence of these two underlying assumptions of medical care is linked to negative understandings of old age. Studies have shown, for example, that clinicians feel that treating older patients is futile (Bagri and Tiberius 2010; Kaufman and Becker 1991) because in many cases, older patients' health problems cannot be cured (Boyd et al. 2005). This can leave health care providers uncertain about what the best clinical course of action should be, and whether the chosen treatment will cause more health problems than it alleviates (Welch, Schwartz, and Woloshin 2011). This project explores some of the ways that doctors, patients, and their companions navigate these uncertainties in a clinical context. Each chapter discusses how problems that are associated with old age, such as older patients' gradual loss of independence, are confronted and managed during interactions in primary care visits.

1.2. AN AGING POPULATION

1.2.1. Demographic changes

Life expectancies across the globe have increased dramatically over the past century. In the United States, most babies born in 1900 were not expected to live past age 50; today, the average life expectancy is 78.74 years (U.S. National Institute on Aging 2011). Although some scholars are beginning to question whether we are approaching the upper limit of the human life span and what that limit actually is (Oeppen et al. 2002), there is widespread agreement that the numbers of older people – especially the oldest old, people who are 85 or over – are still increasing (U.S. National Institute on Aging, 2011; United Nations, 2013). The problem, however, is that health care systems – particularly in the United States – are not equipped to accommodate the sustained care that this generation requires (American Geriatrics Society 2013; Ebrahim 1999).

These demographic changes present not only a challenge to the supply of and demand for services within our health care system, but also a challenge to the way that health care is typically provided. Common recommendations for older adult patients are often based on data collected about considerably younger populations (Wenger 1992) with little or no modification to account for their comorbidities (Boyd et al. 2005) – making the question of whether or not to treat a particular health issue inherently relevant to the elderly. For routine preventive health measures such as cancer screening, for example, the potential risks and benefits can vary wildly among older patients (Ko and Sonnenberg 2005). Thus, determining the appropriate treatment for older patients requires a shift in the way that primary care is typically delivered, which must be negotiated during individual patient visits. In the sections below, I will discuss how the challenges of aging came to be entangled with medicine, and how they are understood by the doctors and patients who must face them together.

1.2.2. The study of aging emerges

With the advent of modern medical treatments like vaccinations, diseases that once killed millions were transformed from a sure death sentence into a thing of the past (André 2003; Bloom 1999). As these improvements decreased mortality for the young and it became common for people to survive to old age (Olshansky and Ault 1986), the study of aging became possible on a much larger scale; aging could be investigated not just among the few elderly individuals in a population, but in the population at large (Katz 1996). Throughout the twentieth century (and particularly during the period of economic growth after World War II), the elderly population reached a critical mass that drew the attention of multiple stakeholders who would help establish old age and aging as a new field in its own right (Katz 1996; Zeman 1950).

During this period, research increasingly focused on aging and the government began appropriating the first federal funds for social services to support older Americans – most notably, the Social Security Act of 1935, the Older Americans Act (OAA) of 1965 and Medicare (Achenbaum and Carr 2014). The institutionalization of aging thus denoted the elderly as a unique demographic group worthy of both federal support and scientific study.

Although recognizing the elderly as a distinct group within the population and attending to process of aging as an object of study made social services like Social Security and Medicare possible, the assumptions underlying the foundations of these programs had unfortunate consequences for aging-related research. Namely, because these programs suppose that people require extra support as a result of becoming old, old age is implicitly associated with the problems that these programs are designed to correct: poverty, failing health, and dependence on others (Katz 1996; Streib 1985). As a result, until recent years much aging-related study focused on negative attributes of aging, the extent of these problems and how to correct them (Covey 1988; Nelson 2005; Streib 1985).

This instigated a cycle that entrenched and reinforced negative perceptions of aging on two fronts; just as the institutionalization of aging set an agenda for the lines of inquiry that were deemed central to understanding the elderly population, findings from this research were in turn used to inform how social services for older adults have been structured and augmented over time. Medicare, for example, was created in part due to lack of interest by private health insurance companies in offering coverage to retirees – many of whom had chronic health conditions and a regular need for health services, making them expensive to insure (Oliver, Lee, and Lipton 2004). Since it was introduced, Medicare has been frequently targeted as a burden to federal budgets (Clymer 1995) and has informed many research studies that document just how extensive healthcare utilization and expenditures among older patients with Medicare coverage can be (Lehnert et al. 2011). This research drove political debates about Medicare coverage, resulting in changes that mirrored the origins of Medicare – lack of interest in paying for the costly medical care of older people – and left substantial medical expenditure burdens to be paid by the elderly beneficiaries who become ill (Long, Settle, and Link 1982). Today, decisions about expanding Medicare and who should shoulder the costs of coverage remain hotly contested as part of national healthcare reform in the Affordable Care Act (Cubanski et al. 2014). This reinforcing cycle thus repeatedly drove home the message that becoming old is problematic and therefore cemented the position of old age in society as undesirable and burdensome.

1.2.3. Medicalization of aging

As improvements in medicine gradually prevented or cured illnesses that were once deadly for many young people, the medical profession became essentially linked to surviving into old age. Through the nineteenth and twentieth centuries, physicians worked to consolidate professional power by reforming medical education, shaping policy, and restructuring medical standards of care (Freidson 1970; Timmermans and Oh 2010). The substantial professional dominance physicians assembled during this time made possible a post-World War II era that scholars have referred to as the “golden age of doctoring” (McKinlay and Marceau 2002). During the golden age, advances in technology and biomedicine facilitated the consolidation of professional power among medical professionals by improving their ability to treat disease objectively (Starr 1982), and consequently, to help people live longer. As medicine continued to help increase longevity, aging came to be viewed as a medical problem (Estes and Binney 1989).

The medical profession’s claim over the aging process led to the trend of biomedicalization of aging, or the social construction and treatment of aging as a medical problem (Clarke et al. 2003; Estes and Binney 1989; Joyce and Loe 2010). As a result, ailments that were once considered normal aspects of aging have become increasingly reclassified as diseases and treated by medical specialists (Forrest et al. 2002; Gubrium 1986; Starfield 2005); loss of vision has become glaucoma, stiff joints are now degenerative joint disease, loss of bone density is now known as osteopenia or osteoporosis, and memory loss can be diagnosed as Alzheimer's disease or other forms of dementia. Though social systems like religion, family, and community defined the boundaries and meanings of aging in the past, the dominance of medicine has since encroached on these aspects of human life and has encouraged society to think of old age in pathological terms (Cole 1992; Estes and Binney 1989; Kaufman 1994). As such, medical encounters are one of the primary settings in which concerns about aging, and aging itself, are addressed.

Despite the erosion of medical authority (Starr 1982) and the end of the golden age of doctoring around the 1970s (McKinlay and Marceau 2002), clinical understandings of aging have prevailed. An important reason was that the declining status of the medical profession made way for a buyer-driven health care system in which patients became treated as consumers (Light 2014). The subsequent rise of commercialism in medicine enabled market interests, like medical device manufacturers and pharmaceutical companies, to create new illness categories just as quickly as they could make new treatments available to the public (Conrad 2005). As Estes and Binney (1989) explained in their landmark paper about the biomedicalization of aging, ‘‘Convinced that only biomedical science can save them [i.e., older people], the solutions to the problems of aging appear resolvable by the purchase and consumption of more and more high-cost medical services and technology’’ (p. 594).

1.2.4. Ageism

As a result, the biomedicalization of aging equated old age with being diseased and disabled, thus engendering both social control of elderly persons through the medical management of their problems and the perpetuation of negative attitudes toward aging (Estes and Binney 1989). For example, studies have reported that people age 65 and over are disproportionately affected by risk factors for heart disease, including hypertension (McDonald et al. 2009), which creates myriad opportunities for older people to be drawn under the medical gaze for testing, treating, and monitoring (Armstrong 1995; Daly and Mcdonald 1997; Welch et al. 2011). Surveillance-driven medical care has promoted the new moral imperative to treat heart problems at older and older ages, especially now that more cardiac procedures are covered by Medicare (Kaufman, Shim, and Russ 2004). It has become so ordinary to perform these procedures on the elderly that older patients themselves often feel that they have no choice but to accept the treatment – despite the perception among clinicians that a sudden cardiac event is a "good" way to die (Kaufman et al. 2004). Consequently, it is common for older patients to feel obligated to endure testing and procedures that may have extensive recovery periods even though doing so will ultimately cause them to fulfill stereotypes of the elderly as being diseased and dependent on others.

This image of old age has contributed to the stigmatization of aging and the development of *ageism* – or, "a systematic stereotyping of and discrimination against people because they are old" (Butler 1989). As described by Robert Butler, who first coined the term ageism, "old people are categorized as senile, rigid in thought and manner, old-fashioned in morality and skills. . . . Ageism allows the younger generation to see older people as different from themselves; thus they subtly cease to identify with their elders as human beings" (Butler 1989, p. 139). Scholars have since noted the prevalence of ageism and ageist language throughout society (McHugh 2003), but ageism is of particular importance in medical settings (Butler 1989; Grant 1996; Greene et al. 1986; Nussbaum et al. 2005). From the lack of prestige associated with caring for the elderly (Album and Westin 2008), to negative attitudes about treating elderly patients (Greene et al. 1986; Weiss and Fain 2009) and inadequate reimbursement for doing so (Besdine et al. 2005), the stigma of aging and old age perpetuates the perceived undesirability of treating the elderly (Estes and Binney 1989), which is consequential for the way that physicians interact with the older patients in their care. In following sections, I will discuss how these persistent expectations about aging have helped to shape interactions between older patients and their health care providers.

1.3. TREATING OLDER ADULTS

1.3.1. Uncertainty around treating older adults

The undesirability of treating older patients has fostered a common understanding among many clinicians that doing so is futile (Bagri and Tiberius 2010; Kaufman and Becker 1991); in many cases, older patients' health problems cannot be cured and there are few guidelines to help inform decisions about what should be done to help (Boyd et al. 2005). Indeed, decisions about medical care for older patients are frequently made based on data collected about considerably younger populations (Wenger 1992) with little or no modification to account for their comorbidities and goals (Boyd et al. 2005).

As a result, health care providers can be left uncertain about what the problem is, what the best clinical course of action should be, and whether the chosen treatment will only cause more health problems than it alleviates (Welch et al. 2011). The biomedicalization of aging in particular has helped solidify older adults' position as complex patients because they can now suffer from increasing numbers of conditions – not to mention, polypharmacy and other adverse outcomes from treatment (Bergman et al. 2007). Thus, determining the actual cause of an older patient's symptoms and the appropriate treatment is challenging and becomes even more so as continued biomedicalization lengthens the list of "concomitant, overlapping clinical conditions, receiving multiple, frequently interacting medications and treatments" (Bernabei *et al.* 2008, p. 308) even further.

The complexity of treating older patients is also partially a definition problem; the typical biomedical directive for treating aging patients is to stave off "normal" declines and to cure problems that are diagnosable diseases (Mykytyn 2008). The difference between decline and disease, however, has proven to be nearly impossible to discern for certain. Indeed, researchers and practitioners have long struggled to distinguish between normal and pathological aging (Bergman et al. 2007; Fried et al. 2004; Holliday 2004). For many clinicians this raises the question, how should older adults be treated, if at all (Bagri and Tiberius 2010; Kaufman and Becker 1991)? And, as this project considers, how can physicians address these patients' complex health issues during the span of a typical appointment?

1.3.2. Gerontology and geriatrics

Biomedicine's claim to aging may have contributed to the problematic understandings of aging that were subsequently advanced by ageism and the anti-aging movement, but it has also spurred efforts to reimagine aging in a positive light (Katz 1996). The field of gerontology – that is, the scientific study of old age (Metchnikoff 1908) – was first introduced around the turn of the twentieth century and slowly developed in tandem with the improvements in health and sanitation that made living to old age more common. It wasn't until the post-World War II period, however, that gerontology began to gain more prominence in medicine (Katz 1996;

Martin and Gillen 2014); gerontology gained its momentum by attempting to combat the common negative perceptions of old age in society through the creation of more positive images of aging (Katz 1996). This goal inspired the pioneering multi-disciplinarity of the field as the few scholars with an interest in aging joined forces in pursuit of this goal. As Robert Kastenbaum once put it, “We often described ourselves as a ______ with a special interest in aging and the aged. (This blank would be filled variously by "psychologist," "biologist," "economist," etc.). After a while, there were enough of us blankety-blanks to persuade at least each other that we now had something resembling a coherent field of research, service, and education” (Kastenbaum 1992). Through its interdisciplinarity, gerontology sought innovation from looking outward rather than through insularity of the field.

Gerontology has solidified as a field and has since gained some notable achievements, such as the establishment of the National Institutes on Aging in 1974, the production of reports about aging by the Institute of Medicine from 1978-1993, and the growth of geriatrics training fellowship programs (Warshaw and Bragg 2003). Yet, the medical branch of gerontology – geriatrics – still ranks at the bottom in studies of medical specialty prestige (Album and Westin 2008) in large part due to ageist attitudes among health care providers (Weiss and Fain 2009). As the previous sections have demonstrated, these negative attitudes toward older people – and toward treating them, in the health care context – have been driven by longstanding stereotypes that convey the message that this group demands more time and resources than is worth investing in them. In health care, this is exemplified by the lack of interest in treating the elderly among aspiring doctors (Bagri and Tiberius 2010; Reuben et al. 1995) and poor incentives and financial reimbursement for caring for the elderly (Besdine et al. 2005). In turn, this has had cascading results that ultimately solidified the status of fields like geriatrics – and the older patients they treat – at the bottom of the medical totem pole.

Despite its low level of prestige, clinicians and scientists agree that for older patients, there are important clinical benefits associated with seeing a geriatrician compared to regular internists (Boult et al. 2001; Gawande 2014). As primary care providers, geriatricians have access to similar resources as their internal medicine and family practice counterparts. This suggests that the difference in medical care lies in the interaction, and indeed, other research has characterized the benefits of seeing a geriatrician as interpersonal in nature (Kaufman and Becker 1991). This study seeks to address this question by drawing out some of the specific differences between how geriatricians and non-geriatrician internists care for their older patients and examining the consequences of such differences.

1.4. INTERACTION IN MEDICINE

1.4.1. Physician-patient interaction

Changes within the institution of medicine – such as shifts in medical authority, standardization, evidence-based medicine, and the rise of consumer interests – transformed traditional expectations of medical encounters. In particular, the concept of "patient-centered care" emerged in response to paternalism and increased standardization. According to a report issued by Institute of Medicine, patient-centered care entails "respecting and responding to patients' wants, needs and preferences, so that they can make choices in their care that best fit their individual circumstances" (Baker 2001, p. 48-50). This perspective prioritizes the physician-patient relationship and highlights the patient's role in medical care, ultimately placing great importance on understanding how communication between physicians and patients occurs.

As such, research about physician-patient interaction has grown tremendously, propelled by early influences such as Parsons' concept of the sick role (Parsons 1951). After the publication of *The Social System* in 1951, scholars almost immediately took issue with the limitations of Parsons' normative conceptualization of the doctor-patient relationship. Szasz & Hollender (1956), for example, drew attention to the variations that exist within doctor-patient interactions based on the severity of patients' sickness and whether the treatment will be invasive (such as surgery) or can be self-managed (medication only). Particularly since the 1970s, studies of doctor-patient interactions have bourgeoned into a vast domain of research that has attracted the interest of many disciplines (John Heritage and Maynard 2006).

By bringing doctor-patient interactions into sharper focus, scholars have used research about the actual content of medical encounters as a springboard for reimagining expectations of what communication between doctors and patient *should be*. Numerous studies have offered suggestions for improving doctor-patient interactions, such as proposing patient-centered frameworks of doctor-patient communication (Ong et al. 1995), advocating for "more training in social and psychosocial sophistication for any physician who has contact with patients" (Zola 1973, p. 686), and arguing that greater patient participation in decision-making is justified (Guadagnoli and Ward 1998).

Despite general agreement around the overall purpose and meaning of physician-patient interaction research, one issue with this line of inquiry is the instability of prevalent patient-centered concepts, like patient satisfaction. As Heritage & Maynard (2006) described in their review of the literature on doctor-patient interaction research, "Abstract statements about this relationship almost universally gloss the complexity and specificity of the actions and responses that make up the medical interview" (p. 353). Previous studies have pointed to the importance of acknowledging the complexity of the medical encounter on the interpersonal level (Lupton 1997), and suggest that future work should delve deeper into the specifics of doctor-patient communication (Timmermans and Tietbohl 2017).

1.4.2. Approaches to studying physician-patient interaction

Several prominent approaches to studying interaction have influenced current research focused on uncovering the intricacies of physician-patient interaction. First, Korsch and Negrete (1972) demonstrated that systematically studying physician-patient interaction led to improved patient health outcomes. By using Bales' (1950) Interaction Process Analysis (IPA), they showed that group behavior could be evaluated by classifying specific behaviors into categories of actions. While IPA was a novel approach at the time, since then scholars have found this approach to be too general to capture the nuances of medical interaction (John Heritage and Maynard 2006).

In response, scholars like Deborah Roter developed more detailed coding schemes such as the Roter Interaction Analysis System (RIAS) that captured additional categories of interaction (Roter and Larson 2002). RIAS continues to be used widely because it enables the analysis of visits across various medical specialties and between social variables (such as age or gender), and its findings are replicable. However, the drawback of this approach is that RIAS focuses heavily on outcomes. For example, this method cannot capture contextual factors such as where the visits take place or how interactants (e.g. physicians and patients) may influence each other over the course of a visit; the expectations and preferences of a patient in the context of routine primary care concerns (e.g. weight) may differ when that same patient is faced with a more serious condition (e.g. cancer).

Microanalytic approaches, however, *can* capture such information. For example, studies by Mishler (1984), Strong (1979) and West (1984) exposed the impact of authority in medical encounters; that is, these studies demonstrated some of the ways that medical authority shaped both the content and structure of interactions between physicians and patients. In particular, the method of conversation analysis emerged as a valuable approach to analyzing patterns in social interaction by connecting symbolic interactionist approaches to ethnography with earlier methods of quantitatively coding interaction (Maynard and Heritage 2005).

1.4.3. Conversation analysis in medical settings

Conversation analysis is based on the logic that medical encounters largely involve conversation and are thus social in nature, meaning that such interactions are subject to the same norms of ordinary conversation. In other words, the interactional practices involved in various actions – such as describing a problem (Jefferson 1988) or delivering good and bad news (Maynard 2003) – remain intact when a person enters the doctor’s office. As a result, this perspective accounts for the influence of both physician and patient; given that studies of ordinary interaction highlight the ways in which people jointly construct interactions (Heritage and Raymond 2005), the contributions of both parties are unavoidably implicated in the co-construction of the medical encounter. For example, previous studies have noted the necessity of patient acknowledgement in response to treatment recommendations (Heritage and Sefi 1992) and that physicians treat lack of acceptance as problematic. As Stivers (Stivers 2005b) found, this can initiate a negotiation between physician and patient that may ultimately change the visit outcome through concessions, re-doing the recommendation, and providing accounts for the recommendation. Thus, by examining medical interactions turn-by-turn, conversation analysis can reveal patterns – and their meaning in a particular context – in the ways that physicians and patients jointly construct medical visits.

These strengths have made conversation analysis a prominent method for studying physician-patient interaction over the past 30 years. Conversation analysis research in medical settings now spans numerous settings, including pediatrics (Stivers 2001, 2005a), adult primary care (J Heritage and Maynard 2006a; Robinson, Tate, and Heritage 2016), surgery (Hudak et al. 2010; Mondada 2014), anesthesia (Hindmarsh and Pilnick 2007), pediatric genetics (Stivers and Timmermans 2016), and neurology (Toerien 2017), to name a few. As rich as the literature involving interactions in adult primary care may be, however, conversation analytic studies focused on *older* adults in this context are limited or reflect older patients' experiences in health care systems that are structured very differently from the system in the US (Coupland, Robinson, and Coupland 1994). Much research in this vein involves end-of-life care. Pino et al (2016), for example, described some of the ways that difficult topics such as end-of-life considerations are introduced and solicited within palliative care for terminally ill patients. While end-of-life discussions are certainly pertinent to older adults, the focus on such concerns does not capture the larger picture of older patients' complex health – and accordingly, the routine conversations and decisions they involve.

1.5. DATA AND METHODS

1.5.1. Research Design

This dissertation employs a combination of qualitative methods: conversation analysis and ethnography. As conversation analysts have described, "conversation analysis examines the social actions that interactants accomplish in and through interaction focusing on sequences of interaction" (Stivers 2005, p. 951). Yet, the study of interaction through an analysis of utterances

– using methods like conversation analysis – must also take into account the context in which those utterances are embedded (Garfinkel 1967). Previous studies have noted the benefit of employing ethnography along with conversation analysis to help understand the particular circumstances of interactions, especially in medical contexts (Heritage and Lindstrom 1998; Lutfey and Maynard 1998; Maynard 2003).

Given that the benefits of seeing a geriatrician have been understood as interpersonal in nature (Kaufman and Becker 1991), conversation analysis lends itself well as a method for studying how doctors, patients and their companions manage aging-related problems in primary care. Toward that end, I draw from four sources of data: 1) video recordings of older patients' visits in a geriatrics clinic, 2) video recordings of older patients' visits in internal medicine, 3) field note observations in a geriatrics clinic, and 4) interviews with geriatricians. The video recordings of older patients' visits will allow me to precisely analyze the specific interpersonal aspects of medical care that may be important in primary care, and how these interactions with older patients may differ between geriatrics and internal medicine contexts. The field notes and interviews will complement these data by revealing the broader clinical context in which interactions between older patients and primary care providers occur, further illuminating participants' understandings of specific terms, courses of action, or other patterns. In turn, the video data provides real-time evidence that complements emergent themes in field notes and interviews.

1.5.2. Setting and Recruitment

Although geriatric services are in demand, the numbers of departments that offer them are few; according to the Association of American Medical Colleges, only eight of the 145 academic medical centers in the United States has full geriatrics departments when these data were collected. Thus, the field site for this project was selectively chosen based on the size and scope of its geriatrics department, comprised of roughly 25 geriatricians across three different locations in the Western United States. The advantage of selecting a larger clinic was that all geriatricians enrolled in the study were subject to the same institutional policies, eliminating system-level variation that could make comparisons between individual visits more difficult.

Patients become eligible to visit a geriatrician at age 65, the age at which they become eligible for Medicare, but patients in this clinic were most often aged 75 or older. Patients arrived at the geriatrics clinic primarily through self-selection, though some arrived through a referral from another physician. Some geriatricians worked full-time at this outpatient clinic, but most worked part-time while also working in one or more other settings (e.g. hospital, skilled nursing facility, hospice, assisted living, research, home visits). Geriatricians could not always accept new patients due to limited availability. During the study period, the clinic was forced to limit new patients to only those who were over age 80 or had more complex health concerns.

Geriatricians first received an introductory email about the study. Only board-certified geriatricians were eligible to participate. I then met in person with those who were interested to obtain informed consent. Subsequent geriatrician participants were recruited based on referrals. Only patients of participating physicians were approached in the clinic about being observed for this study. Patients were considered eligible if they were 65 years of age or older and were able to provide informed consent.

1.5.3. Data Collection

These data were collected in two phases. The first phase involved collection of field note observations and interviews. I first conducted interviews with geriatricians, and then scheduled time to shadow each physician following the interview. Interviews were completed before beginning patient observations to ensure that physician responses about how they typically communicate with patients and perform clinical duties were not biased by my ongoing presence in the clinic. Semi-structured interviews were conducted using a general interview guide covering topics such as 1) physician background and experience, 2) discussing difficult diagnoses, 3) making complex medical decisions with patients, 3) dealing with family members and care takers, and 4) questions about the field of geriatrics more broadly. Geriatricians also completed a brief demographic survey at the time of the interview. Field notes documented observations of patient visits, conversations with doctors and staff between visits, and the clinic in general.

The second phase of data collection involved video recording patient visits and collecting additional field note data capturing observations of the geriatrics clinic. At the beginning of each recording day, geriatricians reviewed their schedule and indicated which patients were ineligible to participate. Patients who geriatricians deemed unable to consent were excluded. To maximize cohesiveness of the video dataset, only patients who were visiting the physician for a routine checkup were included. Visits with medical students shadowing the geriatrician and urgent care visits were excluded. Video data collection followed conventional procedures for Conversation Analytic work, including collecting video and audio recordings for the healthcare consultations in full. A camera was set up in one exam room for recording consenting patients but unlike field note observation data, no researcher was present during the consultation.

In both phases of data collection, patients completed a brief demographic survey at the time of consent. All data were obtained under the proper IRB Permissions, and informed consent was obtained from all participants (including physicians, staff, patients, and any companions accompanying the patient).

1.5.4. Sample

I collected three of the four data sources from one geriatrics clinic in a large urban area: field notes, geriatrician interviews, and geriatrics patient visit video recordings. In the first phase of data collection, I recorded detailed ethnographic field notes describing 70 patient visits (August 2014 – January 2015), and completed interviews with 9 geriatricians (August – September 2014). Six geriatricians were observed around the clinic and during patient visits. Three geriatricians only participated in the interview portion of the study and were not observed due to relocation (n=2) and scheduling conflicts (n=1). Participating geriatricians primarily identified as women (n=7), were aged 31 to 54, and had been practicing medicine for between 6 and 21 years. In the second phase of data collection, video recordings and additional field notes (recorded concurrently) capture 53 patient visits across four geriatricians with varying levels of experience and were collected between August 2016 and September 2017.

The fourth data source is an existing corpus of 180 video recordings of internal medicine and family practice visits collected within the same urban area, during the same time period. These data were generously shared with me by Clara Ann Blomgren Bergen. These video recordings were also collected according to Conversation Analytic conventions. To maximize cohesiveness of the geriatrics and internal medicine data, videos from the internal medicine data set were only included if 1) the recordings were from clinics within the same institution as the geriatrics clinic, and 2) participating patients met the same criteria as those in the geriatrics data (i.e. age 65 or older and able to provide informed consent). Finally, visits that were not conducted primarily in English or required a translator were excluded. This resulted in a collection of 31 internal medicine recordings. Data from the fourth source of data was also obtained and shared under IRB approval and all participants provided informed consent.

Below, Table 1 details some of the relevant characteristics of participating clinics in the geriatrics and internal medicine data sources, respectively.

Table 1: Video data clinic characteristics

	Geriatrics	Internal Medicine
Number of clinics	1	3
Number of doctors	5	7
Number of videos	53	35
Average visit length (approx.)	21 minutes	20 minutes
Average patient age	81 years old	75 years old
Number of visits where patient attends alone	32 (60%)	27 (77%)
Number of visits where companion(s) are present	21 (40%)	8 (23%)

1.6. OVERVIEW OF THE DISSERTATION

At the heart of this project are a few core issues that older patients and their doctors must grapple with each time they meet: the entanglement of medical and non-medical problems, uncertainty about how to address complex health issues, and whether older patients are independent and reliable enough to carry out the recommended course of action. Moreover, these issues are complicated further by a subtle, but important difference in the doctor-patient relationship; primary care physicians who treat older patients must balance the widely accepted goal of maintaining a long-term partnership, while still being aware that these relationships will inevitably end when the patient dies. In this dissertation, I will show how the process of aging, and the problems that are associated with it, are confronted and managed in primary care interactions and how doctors and patients work them out collaboratively.

1.6.1. Chapter 2

In Chapter 2, I begin my examination of aging in interaction by discussing how the stigmatized label of being old is talked about in geriatrics and internal medicine clinics. Ageism has caused old age to be perceived as undesirable and burdensome, and in medical contexts it is also viewed as a hindrance to communication. How, then, can ageism in medicine be managed? A fundamental premise underlying stigmatization is that it can only be enacted and made "real" through social interaction, and accordingly, solutions must also be rooted in social interaction (Goffman 1963; Pescosolido and Martin 2015). In this chapter, I show that even though the label of old age is stigmatized, it can also be mobilized as an interactional tool that facilitates discussions about the uncertainty inherent in age-related health problems.

Chapter 2 utilizes all four sources of data to thematically analyze the implications of explicitly talking about growing old (and being old). These findings suggest that, depending on its design, the label of old age can be mobilized as an interactional tool that doctors and patients can use strategically to *facilitate* discussions about aging-related uncertainty. In particular, I show how mentioning old age enables geriatricians and their patients to a) collaboratively achieve holistic medical care that bridges the gap between the voice of medicine and the voice of the lifeworld, and b) personalize decisions about medical care. In turn, this enables geriatricians and their patients to overcome the stigmatization of aging by mobilizing the category of old age in medical interactions. These practices illustrate how interaction can be used to normalize aging and bridge gaps in physician-patient communication.

1.6.2. Chapter 3

Chapter 3 focuses on another way that patients are encouraged to facilitate communication: that is, to “actively participate” in their medical care. Demonstrating the capacity to actively take charge of their own health is of particular importance to older patients, who must convey this ability if they wish to remain independent at home. Drawing from the geriatrics video dataset, in this chapter I use conversation analysis to explore one practice that older patients use to demonstrate personal responsibility for their health in the doctor’s office. In this practice, which I term *agency framing*, patients design questions to the doctor with phrases that project an intended action, such as “I was gonna ask you”, “I was gonna tell you” or “I wanted to ask you”. I find that by designing questions to include agency framing, patients seek to accomplish more than just seeking information or action. Specifically, patients use agency framing to cast their questions as 1) independently motivated, 2) well-informed, and 3) responsible. Chapter 3 shows that questions designed with agency framing work to portray the speaker as a responsible patient who is not only meeting the bare minimum of expected health maintenance, but is going beyond the call of duty to stay ahead of medical problems.

1.6.3. Chapter 4

Chapter 4 examines instances in which a patient’s health and degree of independence may be irrelevant because the doctor has no treatment to offer. In this chapter, I show that in the absence of clinical options to recommend, doctors can provide empathy. I begin Chapter 4 by addressing the conceptual inconsistencies in what “counts” as empathy in previous research – specifically, by conceptualizing one type of empathy which I term *empathic validation* (e.g.

“that’s really frustrating”). Unlike previous research relying on doctors’ appropriate identification of “empathic opportunities”, I show that providing this empathic validation does not depend on the patient’s ability to create an empathic opportunity. Using conversation analysis, I examine how the design of empathic validation impacts its effectiveness, the context in which doctors provide validations, and their primary functions in these interactions.

In particular, I find that doctors commonly provide empathic validation when there is no medical solution for the patient’s concern. These situations are particularly common among the elderly, whose health problems often cannot be cured and rarely have guidelines to help inform decisions about what should be done to help (Boyd et al. 2005). Within this context, I discuss the three main activities that expressions of empathic validation accomplish: 1) normalizing changes in the patient’s health, 2) acknowledging the difficulty of the patient’s individual situation, and 3) recognizing the patient’s actions or choices. Given that this patient group is growing and that all physicians who are not pediatricians will likely see patients who are older adults, learning more about interactional tools like empathic validation can be beneficial across many specialties and could potentially help reduce ageism in medicine by promoting shared understanding between doctors and patients.

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CHAPTER 2

THE “O” WORD:
USING OLD AGE AS AN INTERACTIONAL TOOL IN PRIMARY CARE

2.1. INTRODUCTION

The literature on old age has shown an ageist bias, highlighting that old age is often perceived as undesirable and burdensome (Butler 1969; Nussbaum *et al.* 2005). In medicine, the effects of ageism are visible on a professional and individual level. Among professionals, ageism contributes to negative attitudes about treating elderly patients (Weiss and Fain 2009) and to inadequate reimbursement for doing so (Besdine et al. 2005). On the patient level, ageism has been associated with a variety of consequences, including decreased likelihood that older patients will seek care (Makris et al. 2015) and detrimental effects on their physical health and well-being (Grant 1996; Whitehead 2017).

Although health care providers enjoy their interactions with older patients (Adams et al. 2002), one reason ageist attitudes persist is the "profound influence of language on the social construction of ageing…in creating and maintaining social structures that perpetuate ageism" (Nussbaum *et al.* 2005, p. 292). Health care communication with older patients requires more skill and patience than visits with younger adults (Bagri and Tiberius 2010), and physicians report that conversations about age-related concerns can be difficult to initiate (Shim, Russ, and Kaufman 2006). Communication challenges reinforce the stigmatization of old age and contribute to medical professionals' avoidance of aging – as the low prestige of medical specialties like geriatrics (Album and Westin 2008) and the trend for physicians to limit the number of older patients in their practices demonstrates (Adams et al. 2002).

How, then, can ageism in medicine be managed? Much research has expanded on Goffman's (1963) ideas about how the stigmatized employ covering and passing to handle stigma in everyday interactions, adding nuance to extant literature about mechanisms for coping and resistance (Link et al. 2002; Thoits 2011). Yet, few studies have explored how the stigma of old age is managed in doctor-patient interactions. In this article, I build on this scholarship by showing that even though the label of old age is stigmatized, it can also be mobilized as an interactional tool that facilitates discussions about the uncertainty inherent in age-related health problems.

A fundamental premise underlying stigmatization is that it can only be enacted and made "real" through social interaction, and accordingly, solutions must also be rooted in social interaction (Goffman 1963; Pescosolido and Martin 2015). Drawing from observations in primary care, I find that physicians and patients both use age to make difficult topics easier to discuss rather than creating a barrier to communication. Additionally, I find that facilitating practices are more common among geriatricians compared to non-geriatrician internists. I discuss how older patients and their physicians take up the category of "old age" in service of bridging the gap between the voice of medicine and the voice of the lifeworld (Mishler 1984) and personalizing older patients' decisions about medical care. Rather than stigmatizing old age, the category of aging can be mobilized to normalize old age and collectively open up topics of discussion.

2.2. BACKGROUND

In medical care, age is more than a number indicating when a patient was born; it is also one of the first pieces of information that health care providers learn about the patient and how they should be treated. The underlying information that a patient's age conveys – such as likely concerns, potential preferences, and health status – may not be explicitly discussed, but comes to bear on medical decision-making nonetheless. Categories like age are inference rich, meaning that identifying someone as a member of a particular group conveys certain information about them that can then be used to infer relevant actions or conversational topics (Sacks 1995). For example, health care providers may likely account for reproductive planning when treating a young adult woman, but not an older woman beyond her childbearing years; fall prevention is rarely discussed with teenagers, but is almost always a priority among older patients.

Although a patient's age can direct health care providers to medically appropriate courses of action, age is also associated with stigma and discriminatory attitudes. For the elderly, this stigma manifests as *ageism* – or, "a systematic stereotyping of and discrimination against people because they are old" (Butler 1989). Ageism and ageist language are prevalent throughout society (McHugh 2003), but ageism is of particular importance in medical settings (Grant 1996; Nussbaum *et al.* 2005) because the elderly comprise the fastest growing patient group in the United States (Schneider 1990). Additionally, the medical profession has been essentially linked to aging and longevity due to the biomedicalization of aging (Estes and Binney 1989). Though social systems like religion, family, and community defined the meanings of aging in the past, medicine has since pathologized these aspects of human life (Estes and Binney 1989). Thus, medical encounters are still one of the primary settings in which concerns about aging are addressed.

Negative attitudes about old age relate to clinicians' sense that treating older patients is futile (Bagri and Tiberius 2010; Kaufman and Becker 1991); in many cases, older patients' health problems cannot be cured and there are few guidelines to inform care decisions (Boyd et al. 2005). Indeed, medical decisions for older patients are frequently made based on data collected about younger populations (Wenger 1992) with little or no modification to account for their comorbidities and goals (Boyd et al. 2005). Consequently, clinicians can be left uncertain about the best course of action, and whether the treatment will cause more health problems than it alleviates (Welch et al. 2011). The dilemma of determining medical care for older patients is compounded by debates about whether aging should be considered a disease or not. Categorizing aging as a disease implies that it is "curable" and a target for intervention (Mykytyn 2006), but considering aging a part of the natural course of human development implies that intervention is not expected (Blumenthal 2003). This tension raises questions about the tradeoffs between pursuing treatment in favor of longevity and the potential impact on older patients' quality of life.

The quest for balance between medicine and patients' lives represents a well-documented struggle between the voice of medicine and the voice of the lifeworld. Physicians tend to speak in a technical, rational way – the voice of medicine – while patients tend to speak about their personal experiences using the voice of the lifeworld (Mishler 1984). Mishler argued that the voice of medicine fragments and suppresses patients' lifeworld accounts, though later studies depict more nuanced patterns of communication (Barry et al. 2001). Rather than overpowering lifeworld accounts, research about bad news communication shows that physicians sometimes work to elicit patients' realizations about how treatment will affect their lifeworld (Maynard 1996).

Newer models of communication have since emerged in response to concerns about Mischler's findings, but it remains unclear how aging fits into theories about physician-patient communication. Models of patient-centered medical care, for example, call for greater patient involvement in medical decision-making (Laine et al. 1996). The cornerstone of such models is open communication (Bensing et al. 2000), but studies report that older patients fail to uphold the responsibilities that these partnership-based models require; older patients have difficulty expressing concerns (Bastiaens et al. 2007) and may have disparate expectations of what patient-centered care entails (Belcher et al. 2006). Older patients themselves are aware of these barriers (Frosch et al. 2012), and many attempt to separate themselves from aging by rejecting the label of being old (Hurd 1999).

Sociological study of such resistance has explored a variety of approaches to managing stigma. Some research highlights the social conditions that contribute to destigmatization (Clair, Daniel, and Lamont 2016), while more research involves individual-level strategies such as contact or education (Corrigan and Fong 2014; Link et al. 2002), and deflecting or challenging

(Thoits 2011). A great deal of stigma reduction literature focuses on mental illness, however, leaving the topic of ageism reduction underexplored. Recent ageism literature has called for more qualitative and observational studies (Levy and Macdonald 2016), and toward that end, this study utilizes multiple sources of qualitative data to show how the label of being old can be used to improve medical communication by both physicians and older patients.

Although old age is often perceived as a barrier to physician-patient communication, I argue that age can instead be harnessed as an interactional tool that facilitates discussions about health problems. As previous studies about medical communication show, language can be used as a tool to make bad news more positive. For example, bright sides – an assertion of a positive aspect of an otherwise negative situation – "can constitute dramatic shifts in the tenor of the interaction because they have the potential to change the valence of the parties' collective evaluation from purely negative to bivalently negative and positive" (Stivers and Timmermans 2017, p. 406). In this article, I explore how age can be mobilized by both physicians *and* their elderly patients to bridge gaps in communication. In particular, I will show how mentioning old age enables geriatricians and their patients to a) collaboratively achieve holistic medical care that bridges the gap between the voice of medicine and the voice of the lifeworld, and b) personalize decisions about medical care. In turn, this enables geriatricians and their patients to overcome the stigmatization of aging by mobilizing the category of old age in medical interactions.

2.3. METHODS

This article draws from four data sources. Three sources were collected from one geriatrics clinic in a large urban area: field notes of patient visits (n=70), interviews with geriatricians (n=9), and video recordings of geriatrics patient visits (n=52). These data were collected in two phases. First, I interviewed geriatricians and observed both patient visits and the clinic in general. Second, I video recorded patient visits for five geriatricians and collected additional field note data of the geriatrics clinic. For both phases, only board-certified geriatricians were eligible to participate. Their patients were eligible to participate if they were attending an appointment with a participating physician, were 65 years of age or older, and were able to provide informed consent.

The fourth data source is an existing corpus of 180 video recordings of internal medicine and family practice visits collected within the same urban area, during the same time period. To maximize cohesiveness of the geriatrics and internal medicine data, videos from the internal medicine data set were only included if 1) the recordings were from clinics within the same institution as the geriatrics clinic, and 2) participating patients met the same criteria as those in the geriatrics data (i.e. age 65 or older and able to provide informed consent). Finally, visits that were not conducted primarily in English or required a translator were excluded. This resulted in a collection of 31 internal medicine recordings. Data from all four sources was obtained under IRB approval and all participants provided informed consent.

The field notes, video recordings, and interviews were analysed using the constant comparative method (Glaser and Strauss 1967). The video recordings and field notes were first examined to identify any instance in which age or aging was mentioned. This included both words and phrases that indicated age or aging (e.g. age, old, older, younger, etc.) and numerical age (e.g. I’m 80). A coding scheme was inductively developed around the resulting collection and each instance was coded using Atlas.ti software. Interview transcripts were then analysed according to the emergent themes and supplemented the primary analysis of field notes and video recordings.

2.4. ANALYSIS

Literature about social interaction shows that our lexical choices influence how conversations unfold and can either close off or open up topics (Schegloff 2007). This is especially important in institutional settings where the topics and contributions of each speaker are predictable; in medicine, for instance, the structure of medical visits restricts opportunities for patients to ask questions (Robinson 2003) while the institutional representative (e.g. physician) is expected to ask most of the questions (Drew and Heritage 1992). Thus, medical professionals can influence discussion topics and patient involvement through their lexical choices. For example, the format of physicians' vaccine recommendations influences the likelihood of subsequent resistance or acceptance of the recommendation (Opel et al. 2013). In primary care visits with older patients, I find that raising the topic of old age serves as one such interactional tool but that depending on its design, it can either impede or facilitate further conversation. In the following sections, I demonstrate how non-geriatrician internists tended to talk about old age in a way that closed discussion, where geriatricians tended to use old age as a springboard for opening up discussions further.

2.4.1. Contrasting clinics

2.4.1.1. The "o" word

Primary care physicians have reported limiting the number of elderly patients they admit to their practices, citing interpersonal and communication challenges among the reasons for doing so (Adams et al. 2002). At the internal medicine clinics that participated in this study, one such challenge involved communicating about aging. Internists attempted to distance themselves from the topic of old age when it arose, conceivably to avoid coming across as ageist. Yet, efforts to skirt around discussions of older patients' age only reinforced prevailing ageist views. In the excerpt below, for example, the internist is discussing a patient's foot pain and has pulled up her most recent x-rays on the computer. The physician points out where the patient's arthritis is located, which the patient is surprised to hear because she was unaware that she had arthritis at all. The internist then provides an explanation about the origins of the patient's arthritis:

> *"…when we break [bones], even one time, when they heal up they're really never a hundred percent again. They're about ninety-nine percent but never a hundred percent. And those are the sites where- that are the weakest. And that's when arthritis or inflammation likes to kick in* ***when we get older. Unfortunately I'm using that 'o' word, but****."*

There are a few ways that this example illustrates the tendency for internal medicine physicians in this study to avoid talking about old age and thus reinforce broader ageist views. First, the physician mumbles the part of the sentence involving old age (in bold), so it is audibly quieter and more difficult to hear. Mumbling the explanation about being older embodies broader negative attitudes toward aging by making this topic less accessible for further discussion. Second, referring to the word "older" as "the 'o' word" marks old age as a taboo subject that should not be named directly. Further, referring to "the 'o' word", draws attention to the patient's age and, consequently, undermines any potential efforts to avoid singling out the patient based on this characteristic. Finally, by characterizing aging-related symptoms as "unfortunate", the physician paints these changes as decidedly negative and suggests that the patient's development of arthritis involves some amount of bad luck. Although old age is not news to aging patients, this reflects previous research about the ways in which bad news tends to be "shrouded" in conversation (Maynard 2003).

In contrast, by leaving out the word "unfortunately" and speaking about old age openly, the physician could have presented these changes as more normal or neutral. In the following sections, I compare visits with non-geriatrician internists to those with geriatricians and highlight the opportunities that avoiding old age tends to miss.

2.4.1.2. Talking about aging

The non-geriatrician internists in this study tended to highlight negative perceptions of aging when they addressed this topic, but often, they avoided talking about old age altogether. In over half of the video-recorded visits, internal medicine physicians never mentioned the topic of old age or aging (52%), and in over a third of the visits (35%) aging was never mentioned by anyone present (including patients, companions of patients, and physicians). This differed greatly from the geriatrics videos, where aging was brought up explicitly in all but a handful of visits (90%) and geriatricians talked about old age in two-thirds of the visits (67%).

When aging was discussed in the internal medicine clinic, patients raised the topic much more often than did the physicians (60% and 40% of instances, respectively). In contrast, geriatricians talked about aging just slightly more often than their patients (47% and 46% of instances, respectively). Additionally, patients' companions also talked about aging more frequently in the geriatrics setting (7% of instances) compared to the internal medicine setting, in which patients' companions did not talk about aging at all.

2.4.1.3. Internal Medicine

On its own, the fact that aging was more prevalent in geriatrics than internal medicine is not surprising; after all, old age defines geriatrics as a specialty. However, closer examination of *how* aging was talked about elucidates the way that old age is understood and treated in each setting. Across the internal medicine visits, the way physicians raised the topic of old age tended to highlight the fact that aging is typically perceived negatively. Like the physician who referred to "older" as "the 'o' word," other internists also acknowledged the undesirability of being old. In one visit, for example, the physician remarks that "you're doing great, I'm always surprised when I see your age," suggesting that the expectation for old age is *not* to be "doing great". In another visit, the physician does this more explicitly by making a joke about being old when the patient is preparing to leave:

> *Physician: Alright* ***young man-***
>
> *Patient: Yes, thank you for calling me young.*
>
> *Physician: ((laughs)) We gotta stick together,* ***we're the age that's falling apart****. Alright you take care.*

By addressing an elderly patient as "young man", the physician singles out the characteristic of age at a point in the conversation when it is not otherwise relevant. Both parties know the patient is not a "young man" and have been discussing his numerous ailments for the past hour, so this comment only serves to underscore the fact that the patient is old. The patient acknowledges the fact that he is not actually a "young man" by thanking the physician for calling him one anyway. The physician then positions himself as part of the same, unfavorable group – people who are "falling apart" because they are aging. Mentioning that they should "stick together" only further casts older people as outsiders in need of support rather than as typical patients.

Internists' attempts to explicitly position the elderly as similar to all patients, however, also failed to normalize old age. This was especially visible in cases where physicians equated the older patient's condition or circumstances to those of younger patients, despite the presence of age-related health concerns. For example, when warning a patient who uses a walker to be careful walking to the bathroom in the middle of the night, one internist added that this recommendation was true for everyone, not just older patients:

> *"It's dark, you know, and you're tired too on top of that when you're getting up to go so just make sure the path is clear because I have seen some people rushing to the bathroom –* ***young people, not even your age****. I'm talking like 30 year old…it's dark, anyone can trip at whatever age you are."*

In this example, the physician raises the issue of walking to the bathroom at night because she is unsure how a new medication might affect the patient's balance. In such cases, conveying that the patient is in the same boat as everyone else may be counterproductive. While anyone can trip, having a fall is less risky for younger people and thus is not a major health concern; someone who is 30, for example, will likely have better balance, better eyesight, will not have to go to the bathroom at night as often, and will not be at risk for experiencing additional health complications after falling. For this 84-year-old patient, however, the recommendation to be cautious is highly relevant; having a fall is a serious concern for older people and can sometimes lead to the patient's death (Welch et al. 2011). Leaving old age unacknowledged thus undermines the physician's recommendation; by saying that *anyone* can trip at night, the physician treats this warning as something they might say regardless of who was in the room. This undercuts the advice to be careful walking to the bathroom at night even though it is a logical recommendation to make for this patient.

In addition to *how* old age was addressed among non-geriatrician internists, the question of *when* this topic was brought up is also significant. Another common theme among the internal medicine physicians was that aging arose within the context of diagnostic uncertainty. That is, physicians mentioned old age when they were unsure of the cause of patients' problems and could not provide a concrete explanation for their symptoms. For example, one physician suggested that the cause of a patient's sudden weight gain could be that "I mean you know, as we get older metabolism gets slower," which the patient rejected and then continued questioning other possible causes.

In similar cases, patients tended to disagree with the attribution of their symptoms to old age and this often resulted in patients asking more questions about their condition. One reason that patients reject this use of aging may be that attributing symptoms to old age closes topics rather than engendering further discussion. Aging is an inevitable process that can't necessarily be "cured", and so attributing symptoms to aging suggests that there is nothing that can be done to resolve the patient's problem. Patients make appointments seeking information and treatments for their conditions, so the insinuation that nothing can be done may well lead to disagreement. Yet, physicians often *do* make recommendations that can improve older patients' health and physical comfort; the patient who was concerned about her weight, for example, ultimately received a referral to a nutritionist and a follow-up visit to reevaluate her thyroid condition. Had the physician chosen not to begin the weight gain discussion by attributing the patient's weight to aging, it is possible that the disagreement could have been skipped altogether in favor of focusing on the patient's treatment options.

2.4.1.4. Geriatrics

To become a geriatrician, medical students must complete a residency in family or internal medicine as well as an additional 1-2 years of fellowship training (Emanuel et al. 2012). An important part of this extra training involves learning how to disentangle the complex medical needs of older patients, which are frequently complicated by multiple conditions, polypharmacy, and physical and mental vulnerability to adverse outcomes (Bergman et al. 2007). Although such problems are common among older patients, geriatricians learn to be cautious about attributing an older patient's symptoms to aging. As one geriatrician noted in an interview:

> *"I was explicitly trained not to attribute symptoms to aging, especially fatigue. However, it's obvious that fatigue, arthritis, etcetera do accompany aging. In a sense,*

> *aging is a diagnosis of exclusion—we should make sure nothing else is wrong with the patient before we call it aging related."*

In a field defined by age, why is this caution so necessary and at what point is it appropriate to introduce "the 'o' word" in conversations with aging patients? In one geriatrics visit, a woman named Patty explained that she believed her blood pressure medication was causing stomach problems. She said that she hates to complain because she had been "accused of geriatric psychosis" during her last visit to urgent care. In that setting, Patty's age was used to dismiss her concerns and this left her feeling unsure of her own judgment about her health. Patty only divulged the root of her health problems after further discussion and reassurance from the geriatrician – that she lost her home four years prior and has been sleeping on a friend's dining room floor.

This example demonstrates the riskiness of talking about age. Attributing health problems to age – which is not strictly a medical problem – can leave patients uncertain about voicing their concerns. If patients like Patty dismiss their own concerns before raising them with a physician, they may never be shared at all. Previous research shows that failure to disclose health concerns is problematic for providing medical care (Heritage et al. 2007), and this concern is even more important for older patients whose multiple health conditions are often interconnected. Yet, as the sections that follow will show, talking about age with older patients can also improve physician-patient communication. Rather than creating a barrier, old age can instead be used as an interactional tool that makes difficult topics easier to discuss.

2.4.2. Achieving holistic care

2.4.2.1. Normalizing patient symptoms and experiences

In many instances geriatricians used age to normalize patients' experiences, despite the fact that symptoms like pain, fatigue, or loss of mobility are not generally considered "normal". The key distinction that geriatricians made was that these types of symptoms are not *caused* by old age, but that they are frequently *associated* with it. The contextualization of a patient's health within their age range is pertinent to diagnosis and treatment, but doing so can be challenging. If done incorrectly – as Patty's case demonstrates – clinicians may risk inappropriately dismissing the patient's concerns and hindering future communication.

As a solution, geriatricians typically avoided mentioning age or aging in reference to the patient as an individual and instead referred to larger age-defined groups such as "older people", "mature people", or "people in your age range". This lexical choice avoids attributing the patient's symptoms to age by instead associating the patient's experiences with those of other patients and alluding to a shared illness experience. In turn, this makes the "abnormality" of older patients' symptoms seem more normal in the sense that these problems are common and expected among others who are like the patient. For instance, in the following example, one patient asked the geriatrician about a new concern regarding a heart murmur, which another physician mentioned in passing as part of a pre-surgery check-up:

> *Physician:* *So, it sounds like the type of murmur we have-* ***after we get older****, there's the aortic valve, which is the main valve of all the blood coming out of the heart.* ***As we get older*** *that valve can become tough or not as flexible as-*
>
> *Patient:* *Hard, hardens-*
>
> *Physician:* *Right. And when the blood flows through that type of valve, instead of being quiet, as it becomes stiffer like that, it changes the dynamics of the flow of the blood. It causes turbulent flow which causes a murmur. That's what that murmur sounds like. So,* ***many of my older patients have it****, it's not of concern to you.*

Framing the patient’s symptoms in reference to a group like “older patients” avoids suggesting that the patient was delinquent in taking care of his health – a concern he expressed just prior to the physician’s response above. Specifically, the patient explained that he always had a fast heartbeat and worried that his past athletic activities may have compromised his heart and caused the murmur. By referring to what generally happens as “we” get older, this approach diffuses the implied patient responsibility for causing health problems; the murmur is normal and expected rather than caused by the patient’s own behavior and choices. In light of the increased level of patient responsibility that is part and parcel of patient-centered care, such diffusion of blame is meaningful.

These benefits also extended to family members who were the primary caregivers for patients. In one visit, a patient’s adult daughter drew attention to some swelling in her mother’s legs. The geriatrician explained that, “in mature people the veins don’t always work well and can leak, hence the swelling.” In this case, explaining the patient’s swelling in reference to other “mature people” normalized this symptom and also communicated to the daughter that her mother’s symptoms are not related to the quality of the care she provides. The swelling is attributed to something biological – veins not working well in mature people – and not to something she could have prevented as the primary caregiver. In this way, talking about aging is a tool for the geriatrician to validate caregivers too.

The distinction between referring to a particular patient’s age and referring to a more general group such as “older people” is also critical because complex geriatric work often necessitates the adoption of a more holistic approach to medical care than the traditional medical intervention-focused view allows (Alkema and Alley 2006). The exclusion of elderly patients from clinical trials (Epstein 2008) has left few standardized guidelines that address the intertwined nature of older patients' health problems. As a result, geriatricians adopted a more holistic view of their patients' health and often made recommendations that went beyond physical measurements of health and accounted for other facets of the patient's life, such as their hobbies and personal goals. The choice to reference the larger patient group is reflective of geriatricians' holistic approach to care; talking about the health of "older people" expands the scope of focus beyond the individual patient.

Discussing the relevance of age also supported a holistic approach by helping geriatricians validate treatment options involving lifestyle changes rather than medical interventions. Geriatricians in this study, for example, suggested that patients take up tai chi to prevent falls, to eat meals with others to improve appetite, or to eat salty foods to help with low blood pressure. The difficulty with recommendations for lifestyle changes is that they could imply that the patient might have been able to address the problem at home rather than coming into the physician's office. As some studies of physician-patient interactions have shown, offering non-antibiotic treatments (such as at-home or over-the-counter remedies) is frequently met with resistance (Stivers 2005b). The resistance to such recommendations may stem from the assumption that a non-prescription treatment implies: that the patient's problem is not a medical one and could have been treated without visiting the physician. By framing a patient's health problems within the broader context of "older people", however, geriatricians position these kinds of recommendations as within the domain of medical care. As specialists whose expertise lies in the treatment of older patients, mentioning age serves as the bridge that makes these nonmedical suggestions appropriate.

2.4.2.2. Expanding medical relevance

When patients mentioned age or aging, they often did so in order to raise a concern that lay on the border of medical relevance. One strategy patients used was to relate their health experiences to aging, making statements such as "maybe it's just old age" or "I'm only 86 and I'm falling apart". This approach was typically used when patients expressed problems that were of personal concern to them, but of ambiguous relevance to the medical interaction. For example, consider the following example with 78-year-old Nancy, a clinical psychologist who was primarily concerned about her memory:

> *"The patient sighed and said 'I look better than I feel' … She then looked a little dejected and said,* ***'I don't mind getting old, I just don't want to lose my abilities'*** *… [the patient] went through a mental checklist of her concerns, such as weakness in her legs after doing tai chi and feeling overwhelmed with organizing a conference she was in charge of. This troubled her because she couldn't remember things… and found herself having trouble carrying out these tasks even though she normally would have found them simple. At this point, [the geriatrician] provided a summary statement of what she had said, saying that it sounds like she 'loses her charge' and that she seems to have a slow start but still is getting things done. The patient nodded eagerly and agreed"*

These kinds of concerns appeared to give patients pause because, on the one hand, they may be related to a particular health issue (in Nancy's case, memory), but on the other hand, the root of the concern is more personal in nature and thus its relevance to the visit was less certain. In the excerpt above, Nancy's comment about not wanting to lose her abilities is related to a concern about memory but also hints at her fears about losing her personal identity as a member of her intellectual community. If she does have a disease like Alzheimer's as she fears, she will no longer be able to stay connected to the work and colleagues she has known for decades; she will no longer be an active clinical psychologist and will no longer remember the things she currently knows.

Although concerns about identity may not always be relevant in primary care, concerns about getting old fall squarely within the geriatrician's domain. Just as the geriatricians use age to relate patients' everyday lives to medical care, here, Nancy uses age as a bridge to make the topic of personal identity relevant to the medical context. In this manner, patients and geriatricians both used age to broaden the scope of medical relevance, and in turn, facilitate a more holistic approach to medical care. Despite the historical tendency of the voice of medicine to overshadow the voice of the lifeworld (Mishler 1984), the voice of aging brings these perspectives together.

Although geriatricians could choose not to respond to patients' comments about aging and steer the conversation in another direction (e.g. ask about the next item on the patient's list), geriatricians rarely did so. More often, they responded by normalizing the patient's experience. Nancy's geriatrician, for example, de-escalates her fears by rephrasing her problem in a more positive light; saying that she loses her charge but is still getting things done positions Nancy as prevailing despite her symptoms rather than invoking the sense of gradual decline that comments like "we're the age that's falling apart" call to mind.

Another strategy that patients employed toward this end was to reference the age of someone else they knew in order to express underlying fears about aging. This often invovled extreme cases such as someone who died too young, someone who lived too long, or someone who was still healthy at a very old age. Consider the example below with 77-year-old Mary:

> *"[The geriatrician]… told [the patient] that [her lab results]say she is fine. The patient was relieved and said "I love nothing better than to hear that I am fine."* ***She then told [the geriatrician] a story about how she had a friend who was only 59 die recently****, so she's glad to hear that she is fine. [The geriatrician] nodded and said that you just have to live every day as you can, and reiterated that her labs looked "smashing". The patient responded by telling [the geriatrician] about a different person she knows who had a*

> *stroke, and wasn't found until 12 hours later so there was less that could be done for her at that point. She said that this woman has been slowly degrading since then, and now has a feeding tube."*

In this excerpt, the addition of her friend's age bridges the gap between a story that provides general information about Mary's life and information that is medically relevant. Storytelling allows patients to create an opportunity to share their own concerns, and age makes these stories relevant to share with a geriatrician. Mary was in fairly good health and could still live independently, but feared having her life either cut short or prolonged to the point of requiring life sustaining technologies. Rather, she wished to live out the rest of her life with as little intervention as possible, as independently as possible, for as long as possible. Even though it was not the purpose of her visit, Mary's incorporation of age into her story made end-of-life concerns medically relevant; indeed, the geriatrician interpreted her story as such and subsequently asked Mary if she would like to complete a Physician Orders for Life Sustaining Treatment (POLST) form so that they could record her preferences in writing, which Mary gladly obliged. Thus, rather than making conversations more difficult between patients and physicians, age can help them to collaboratively meet the patient's needs. Pleased with their joint accomplishment after completing the POLST form, the patient smiled and asked me, "aren't we good?"

2.4.3. Personalizing medical decisions

2.4.3.1. Adjusting patient expectations

In addition to facilitating holistic care, talking about age also helped geriatricians and patients personalize medical decisions for specific health concerns. Making choices about medical care for older patients can be difficult because their health issues can often be managed, but not cured. Coming to terms with this dimension of medical decision-making adds a layer of complexity because expectations of health – on the part of both patients and physicians – can influence subsequent health outcomes (Davis et al. 2011). Clinician expectations of aging can have a serious impact on the patients' health; unrealistic expectations, for example (either too low or too high), can be detrimental to patients and contribute to feelings of inadequacy (Davis et al. 2011). Yet, clinician expectations may also help support patients' health. Geriatricians in this study, for instance, used age as a method for subtly shaping realistic expectations of what can be accomplished in the visit and how patients could expect to feel. For example, consider 67-year old Frank, who scheduled a consultation with his geriatrician to discuss memory concerns:

> *"**[The geriatrician] encouraged Frank not to worry too much, since occasionally forgetting names at age 67 is normal and since he has been keeping on top of his memory changes.** Frank nodded along and appeared to be somewhat comforted by that … [The geriatrician] reassured him that for now he has mild cognitive impairment (MCI), which could be a stable MCI and never progress further. However, if it does progress, [the geriatrician] says they will investigate further to learn the cause but they may never need to go there …"*

In this instance, Frank's geriatrician tells him that although they can try their best to keep him as healthy as possible (e.g. by monitoring his memory changes), he should expect some amount of memory loss (e.g. forgetting names at age 67 is normal) even if his condition remains stable. The geriatrician uses age to both normalize Frank's particular health problem and to personalize a course of clinical action; explaining that forgetting names at age 67 is normal communicates that Frank's experience is common among other patients, but also that some level of "abnormality" is normal for him personally as someone who is 67 years old. Whereas simply stating that Frank shouldn't worry because occasionally forgetting names is normal could be perceived as a dismissive response, the geriatrician's addition of "at age 67" personalizes the recommendation. Thus, the problem of Frank's memory loss is couched as an issue for people his age, not just him alone, at the same time that his own treatment plan is personalized for him as an individual.

In another case, field notes described how one geriatrician discussed the tradeoffs of a cholesterol medication, explaining that "there isn't much data about the effects of his cholesterol medicine for *people in his age range*, so the actual benefit he may be getting could be small". Here again, the geriatrician used age as a tool to uncouple the uncertainty around the patient's cholesterol medication effectiveness from the individual while also personalizing the patient's treatment regimen. Specifying that the effects of the medication could differ for him – a man in his 90s – allowed the geriatrician and patient to initiate a discussion about whether the patient would personally prefer to continue taking the medication anyway or to discontinue it.

Importantly, this helped geriatricians distinguish between *stability* and *abnormality* among older patients. Although patients typically visit the physician's office to remedy a particular health problem, this goal is less realistic for older patients who may never fully recover from all of their ailments. As a result, geriatricians concentrated on stability – not eradication – as the true goal of care. Focusing on stability facilitated personalized medical care because this perspective is inherently attentive to the patient as an individual – a subtle, but critical shift. Scholars have consistently noted that the elderly are a medically heterogeneous group, and so stability for one patient cannot always be assessed in comparison to the rest of the group as standardized guidelines recommend. Rather, geriatricians measured the stability of an older patient in reference to his or her own body during previous visits.

Although geriatricians used age to recalibrate patients' expectations according to the health outcomes they could reasonably anticipate – typically, that they may never fully free of health problems – these kinds of statements never stood alone. When geriatricians mentioned age to communicate that a patient may never feel completely healthy again, they always followed such statements with a discussion of options that could help (enroll in a tai chi class, reduce medication dosage, keep the same medication regimen, etc.). It is this aspect that differentiates whether mentioning age may be validating or dismissive, like Patty's experience in urgent care. While other clinicians report feeling that there is little they can do medically for older patients (Kaufman and Becker 1991), geriatricians' use of age made many nonmedical recommendations relevant. Consequently, this communicates to the patient that even though perfect health is not an option, they are not powerless to improve their symptoms and there is hope for a personalized plan to make them more comfortable.

2.4.3.2. Expressing treatment preferences

Patients also mobilized age as a tool to personalize their medical care. In particular, older patients used age to lobby for a particular treatment or course of action. In the following case, 77-year-old Elaine is discussing her coughing problem with the geriatrician and references her age to make the case for not switching her current allergy medicine:

> "*She takes Zyrtec D and has been feeling great…[The geriatrician] asked if she needs the 'D' or if she's tried taking just regular Zyrtec before. [The geriatrician] explained that the D is for 'decongestant', and wondered if she needs that part because it can increase her blood pressure. Elaine's response was that* ***'I won't live forever, who gives a damn.*** *I would rather be clear than worry about blood pressure'. [The geriatrician] said that she's ok with it if Elaine wants to keep taking it, but just wanted to put it out there because some people find they don't need both parts. Elaine shook her head and said she feels great taking it, so they agreed she would keep doing so."*

In this example, Elaine uses age to express her personal preference about the medication. Here again, age makes Elaine's comment relevant to the setting. In this instance, however, age also serves as a bargaining chip that Elaine uses to advocate for her preferred course of action – to defend her preference for maintaining her existing allergy regimen. Similarly, other patients pushed for specific treatment options by linking aging-related circumstances to health in even more explicit terms. For example, one patient used age to advocate for a new antidepressant:

> *"Well I- I'm sure it's situational you know, I've lost a bunch of friends and I have a bunch of others who are in worse shape than I am, and uh, I think* ***when you're ninety years old*** *and you're losing friends and you feel like hell, I would call that situational".*

Previous research has suggested that patients may be hesitant to express concerns for fear of overstepping the physician's authority (Frosch et al. 2012), but as these examples demonstrate, mentioning age may provide older patients with a means to overcome this worry. Models of patient-centered care often position patients and physicians as experts in their own right – physicians as experts in medicine, and patients as experts in their own body – and for older patients, age is a tool for claiming this expertise and influencing medical decision-making.

In other cases, patients mobilized age to personalize medical care to initiate a discussion about a possible treatment option rather than to expressly lobby for a particular choice. The example below involves a 95-year-old patient, Andrea, who is unhappy about her age. She feels that she has been alive for too long but is still relatively healthy. Andrea says she is in a lot of pain and routinely asks her geriatrician about medical aid in dying, which the geriatrician cannot provide. After her physical exam, she tells her geriatrician that "being old ain't fun. I used to like clothes. I used to like a lot of things," to which the geriatrician responded:

> *"She then learned towards Andrea and told her that she just wants her to feel as good as she can feel. Andrea thanked her and said she knows, and that she appreciates that, but… [the geriatrician] laughed and said that she doesn't have 'those other options' available – meaning the medical aid in dying she keeps asking about. Andrea shrugged and said she was just having an open conversation, and that she feels that she has been*

> *alive too long. [The geriatrician] asked if there was anything else, and the patient said, 'you're not cooperating, you're not shooting me'. [The geriatrician] barked a short laugh and said 'I don't even know how!' as she turned to the computer to write in some notes. Andrea said that she could learn, and that she's been living like this for too long."*

When Andrea first mentions age, she expresses her unhappiness to the geriatrician (being old ain't fun. I used to like clothes. I used to like a lot of things). This usage of age, though less direct, is similar to Elaine's case; Andrea mentions age to give credence to her preferred course of action, but does so as a precursor to the request for treatment itself. By associating her age with her current unhappiness and pain, Andrea lays the groundwork for the request about medical aid in dying.

Thus, patients can use age to both initiate a topic of concern and to shape medical decisions. The geriatrician's choice to follow up on these comments, however, determines the course of action; addressing or ignoring comments about aging is a subtle way for the geriatrician to indicate whether the patient's concern is relevant and treatable or not. This is perhaps best demonstrated by a rare case in which a geriatrician *did not* follow up on a patient's comment about age. This patient, a woman in her 80s, was primarily concerned with foot pain. She requested a prescription for a stronger pain medication and then subsequently made a complaint about being alive for too long. This geriatrician consistently responded to similar patient complaints about being too old in other visits; one comparable instance resulted in a discussion about end-of-life care preferences and the completion of a POLST form. In this case, however, the geriatrician chose not to comment on or ask a question when "the patient seemed irritated and said that she guesses she takes after her mother who lived to 103, which she thinks is much too long." After the visit, the geriatrician explained this choice:

> "*We all said goodbye, and [the geriatrician] and I went out into the hallway…[the geriatrician] told me that the reason he was a little bit dismissive with the last patient was because she has had severe depression for a long time, and electroconvulsive therapy has been the only thing that works for her. She's been doing it for the last fifteen years, and [the geriatrician] says that she usually develops some pains like those she described today that are related to the depression flare ups, so he doesn't want to give her any strong medications."*

Rather than prescribing the stronger pain medication she requested, the geriatrician instead massaged the patient's foot to provide some relief. In this way, *not* talking about aging when it would normally be appropriate allows geriatricians to negotiate the delicate balance of complying with the patient's wishes and drawing on medical authority in decision-making. Just as following up about a patient's comments about age can validate his or her preferences about medical care, the choice *not* to follow up about this can be just as meaningful in the interaction.

2.5. DISCUSSION

Stigma is enacted through social interaction, and in medical settings, physician authority figures are in a privileged position to shape the meaning of stigmatized labels like "old". In some cases, physicians deliberately stigmatize behaviors like smoking to discourage patients from doing so (Timmermans and Tietbohl 2017). Unlike smoking, however, reaching old age is often seen as a goal of care and is not something that patients can avoid once they achieve it. In this context, physicians can use their interactions with patients to help destigmatize old age. As this article has shown, rather than talking about old age in a way that – even if unintentionally – perpetuates ageist attitudes, physicians can instead mobilize old age as an interactional tool that destigmatizes and facilitates holistic, personalized medical care.

In a special issue about aging, sociologists Kelly Joyce and Meika Loe reported that "we use 'old' to defy social stigma, to naturalise and neutralise ageing, and to emphasise social stratification related to age" (Joyce and Loe 2010a, p. 173). This study speaks directly to this sentiment and shows that by talking about old age openly, physicians also have the power to normalize aging and to ease some of the stigma associated with being old. Non-geriatrician internists in this study tended to either avoid talking about old age or highlight prevailing ageist attitudes when they did discuss it; visits with geriatricians, however, demonstrated that old age can improve physician-patient communication. Physicians often think in exceptions, such that single instances of fatal errors can lead physicians to minimize problems that pale in comparison to the exceptional case (Bosk 2003). Rather than using horror stories to minimize problems or to justify testing and treatment, talking about aging allowed geriatricians to take the position that things may not be perfect, and that is normal and okay.

Much like bright sides, "the 'o' word" can play an important role in shaping participants' understanding of the circumstances at hand. Talking about aging openly can help establish a new frame of reference that does not stigmatize the patient for being old or for having conditions might not completely heal; rather, talking about old age allows the physician to focus on what *can* be done to maintain the stability of the patient's health and to accept the things that may never be the same as they once were. Thus, talking about age shows that it has "a silver lining, which may give them a ray of hope to continue a challenging caregiving journey." (Stivers and Timmermans 2017, p. 416).

The potential of age as an interactional tool that could help physicians adjust unrealistic patient expectations of what medical care can accomplish may be critical to current and future efforts to educate clinicians in geriatric care. As research about medical students' perspectives on geriatrics and geriatric education have shown, negative attitudes about treating elderly patients may limit the effectiveness of teaching efforts (Bagri and Tiberius 2010). If strategically discussing age with older patients can indeed aid the management of patient expectations, this approach could help resolve this common difficulty among aspiring physicians.

Furthermore, this paper also shows that older patients possess more skill in medical communication than previous research has indicated. Figuring out what should be done for their complex medical needs is difficult for everyone involved, but as this paper shows, older patients can enable this process by initiating discussions about their age. Still, the success of such techniques relies on the ability of geriatricians to detect these comments and on their choices about whether and how to respond. Future studies should explore this topic in greater depth to potentially inform medical education and in turn, patient care. In turn, these findings could help address some of the common issues that non-geriatrician physicians have with treating older patients, and could help bring together the ideals of patient-centered care and the messy reality of older patients’ health.

Finally, the approaches to talking about old age described here could also be extended to inform efforts to improve communication across a broader range of topics such as gender, sexuality, or stigmatized medical conditions. Just as physicians’ attempts to avoid talking about aging in this study only underscored the stigma of old age, problematic concepts like “colorblindness” that silence discussions about race and its impact on people’s lives cannot change stigma. Strategies for stigma reduction have been met with varying degrees of success, and full destigmatization is difficult to achieve (Corrigan and Fong 2014). Perhaps these findings about how physicians employed the label of old age towards a mutually beneficial purpose could provide insight into additional new solutions.

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CHAPTER 3

“I WAS GONNA ASK YOU”: HOW AGENCY FRAMING DISPLAYS PATIENT ENGAGEMENT IN PRIMARY CARE

3.1. INTRODUCTION

The message that patients should be responsible for their health is more pervasive now than ever. Direct-to-consumer advertising and health promotion campaigns encourage patients to “ask your doctor” about potential illnesses and treatments, and preventive medicine guidelines call for patients to engage in regular self-monitoring to avoid future health problems. Newer models of health care delivery echo this notion; popular models like shared decision-making, for example, advocate for greater patient involvement in making medical decisions. Patient engagement within primary care in particular is critical to the success of other health care reforms that, like shared decision-making, aim to tailor medical care to individual patients’ needs, preferences and circumstances (Cosgrove et al. 2013).

Prior research suggests that these reforms “depend upon patients being willing and able to engage in care and take actions to improve their health” (Fleming *et al.* 2017, pg. 11). Studies of patient-centered care, however, focus more on physician behaviors than on the skills that are required of patients (Ishikawa, Hashimoto, and Kiuchi 2013). What, then, constitutes “patient engagement” in primary care, and how can physicians determine whether patients are sufficiently engaged? Research about patient engagement in safety-net clinics shows that although sometimes providers perceive tangible measures like medication adherence and successful self-management as indicative of engagement, such indicators fluctuate over time as the patient’s health and circumstances change (Fleming et al. 2017). Thus, physicians often used intuitive or impressionistic assessments of patients' interest in care, motivation to meet goals, and positive orientation towards medical providers to evaluate engagement – and importantly, to decide what treatment to provide and to whom (Fleming et al. 2017).

In this article, I build on these findings by examining one interactional resource that patients use to display engagement in another primary care setting with limited numbers of physicians: geriatric medicine. Drawing from video recordings of medical encounters with older patients and geriatricians, I describe how patients' question design can highlight their engagement in medical care and I discuss its implications for physician-patient communication in general and in relation to aging.

3.2. BACKGROUND

Approaching concepts like "patient engagement" from an interactional perspective can help clarify the specific skills that patients need to succeed in the changing health care system. For instance, previous research shows that a primary way patients can participate in medical dialogue is to ask questions (Roter 1984; Street 1991), and that asking questions is viewed as an indicator of patient participation (Street and Millay 2001). Patients may reap multiple benefits from asking questions, such as receiving more information (Street 1991) and feeling more satisfied with care (Kaplan et al. 1996). Yet, patient questions are relatively infrequent in medical visits (J Heritage and Maynard 2006b; Street and Millay 2001), in part because finding opportunities to do so can be challenging. In institutional contexts it is often the professional who asks most of the questions (Drew and Heritage 1992), and the structure of medical visits further restricts opportunities for patients to do so (Robinson 2003). These structural constraints lead to two interactional dilemmas for patient questioning: negotiating contiguity and negotiating entitlement.

Conversation analysts have demonstrated the importance of contiguity in social interaction; that is, there is a preference for each utterance to be understood as advancing the immediately preceding talk (Sacks 1987). Accordingly, speakers often design their turns to display connection to what was just said. For patients, the preference for contiguity presents an interactional dilemma. On the one hand, they may struggle to find openings to ask questions without disrupting contiguity given that physicians tend to drive medical interactions through activities such as history-taking. On the other hand, when patients do have opportunities to ask questions, it can be difficult to convey that their concerns originated from independent thought rather than in response to the preceding talk; each utterance in a conversation comes after what came before it (Sacks 1995), making it challenging to view any utterance as separate from the previous one. In an age when patients are encouraged to actively participate in their medical care and to communicate competently about it (Ishikawa et al. 2013), how can patients show that their inquiries are independent and not just responsive to the doctor? This article will discuss how patients negotiate these contiguity concerns by asking questions that are designed with *agency framing* during primary care visits.

A second interactional dilemma involved in patients' question asking is the negotiation of entitlement, or rights to knowledge. Despite the predominance of health care models requiring higher levels of patient involvement in medical care, patients remain sensitive to the presence of medical authority and tread carefully when communicating with physicians. For example, patients exercise caution when engaging in assertive behaviors (Bergen and Stivers 2013), and can feel compelled to defer to physicians for fear of being categorized as "difficult" (Frosch et al. 2012). Consequently, patients must manage the delicate balance of traditional social roles in medicine with current expectations for full engagement in health care.

One resource for addressing issues of entitlement in social interaction is question design. According to Curl and Drew (2008), question format is associated with speakers' entitlement to ask and the contingencies that may be associated with granting the request. Questions formatted with modal verbs (e.g. can you), for example, index a higher degree of entitlement to ask than do questions prefaced with "I wonder if". Patients more often use the low entitlement "I wonder if" format when asking physicians questions (Curl and Drew 2008), supporting the idea that patients still defer to medical authority. However, rather than using question design to construct themselves as lacking entitlement, in this article I describe how the similar – but distinct – practice of designing questions with *agency framing* can have the opposite effect. I will show how phrases such as "I was going to tell you" convey the stance that patients are fulfilling the expectations of a "good" patient by being proactive in their health care management.

The dilemma of how to present oneself as responsible rather than responsive is especially pertinent to older patients, who tend to have multiple, chronic ailments (Lehnert et al. 2011) and may ask fewer questions (Eggly et al. 2006). Since personal involvement in managing illnesses is particularly relevant for chronic illnesses (Bodenheimer et al. 2002), older patients may experience this pressure to self-regulate and manage their conditions to an even greater degree. For these patients, demonstrating responsibility for health management has higher stakes; at some point, as health declines with age, older patients may no longer be able to remain independent.

In this article I will explore one practice that older patients use to demonstrate personal responsibility for their health in the doctor's office. In this practice, which I term *agency framing*, patients design questions to the doctor with a specific type of action projection, or phrase that projects an intended action (Schegloff 1980). While action projections can serve multiple purposes including pre-tellings or pre-requests (e.g. can I ask you a question?) (Schegloff 1980), I find that agency framing constitutes a unique form of action projection that patients use for particular purposes. I argue that by designing questions to include agency frames such as “I was gonna ask you”, “I was gonna tell you” or “I wanted to ask you”, patients seek to accomplish more than just seeking information or action. Specifically, patients use agency framing to cast their questions as 1) independently motivated, 2) well-informed, and 3) responsible. In so doing, patients exert agency within the confines of the medical visit structure to resist the potential interpretation that their question was responsive to the doctor or to the local interactional context. Rather, this allows patients to show that their question was considered on their own in advance of the visit. Consequently, I argue that questions designed with agency framing work to portray the speaker as a responsible patient who is not only meeting the bare minimum of expected health maintenance, but is going beyond the call of duty to stay ahead of medical problems. I conclude by discussing the particular importance of this practice among older patients, for whom demonstrating a willingness and ability to cope with medical problems may be significant for maintaining independence.

3.3. METHODS

This article draws on a corpus of 52 video recordings of patient visits in a geriatrics clinic located in a large urban area of the United States. Patients were eligible to participate if they were attending an appointment with a participating physician, were 65 years of age or older, and were able to provide informed consent. Videos include four different board-certified geriatricians with varying levels of experience and were collected between August 2016 and September 2017. All data was obtained under IRB approval and all participants provided written informed consent.

Data were analyzed using conversation analysis. Both the author and a research assistant reviewed the entire data set to identify all questions produced with *agency framing*, a form of action projection (Schegloff 1980) defined here as any phrase that projects the type of action that will follow (e.g. "I wanted to ask you" projects that a question is forthcoming). Vaguer formulations that did not indicate a particular action, such as "the other thing is", were not included. This collection includes a total of 62 cases. For comparison, the author then identified all questions asked by patients and their companions across the entire data set. Because this article focuses on physician-patient interaction, only questions addressed to the doctor were included. Questions between patients and their companions were excluded.

The questions in this collection of 62 cases were then examined closely and analyzed with particular attention to the design and function of agency framing in relation to where each case occurred in the local sequential context and within the overall interaction. In this article, I discuss how agency framing allows older patients to portray themselves as independent and competent collaborators and the potential implications that this can have on their overall medical care.

3.4. ANALYSIS

3.4.1. Question design with and without agency framing

Questions come in many forms and the way speakers choose to design them can impact their meaning. This article focuses on one specific aspect of question design: the inclusion of agency framing. Patients can certainly ask questions without phrases such as "I wanted to ask you," and oftentimes they do. Across the overall data set, for example, most questions patients and their companions asked did not include agency framing (n=286). What, then, does agency framing accomplish when it is included in patients' question design? In other words, why that now?

There are two primary distinctions between questions that are designed with agency frames such as "I was gonna ask you" and questions that are designed without them. First, patient questions that are designed without agency framing are frequently responsive to the doctor and to the local sequential context, and accordingly, are hearably built on the preceding turn. In contrast, patient questions that include agency framing work to resist this interpretation.

For example, consider Extract 1 below. In line 8, the patient asks a question outright that builds on the topic proffered by the doctor in lines 1 and 2, determining whether or not she needs to have any blood work done before she leaves the clinic. After checking the electronic medical record, the doctor determines that the patient's blood work is up-to-date since "it was only a couple months ago" (line 5). As doctors cannot proceed beyond this phase of the visit until the patient has agreed with the treatment recommendation – in this case, that no testing is necessary – the doctor adds an assessment in line 7, "so you're good" that pursues a response. Rather than agreeing with or acknowledging this assessment, the patient (who has diabetes) produces a post-expansion and asks if the doctor has seen anything about her blood sugars in line 8. This question implies that the doctor's assessment that "you're good" may not be correct and holds open the topic of blood work rather than moving on with the visit. Thus, the patient's question is directly built on the doctor's response and is intended to continue this line of conversation rather than distance herself from it.

Extract 1 (P102_73yoF_9:10) – saw it on TV

1   DOC: You can have a seat again. Let's make sure you don't need any
2   blood work.
3   PAT: Oh kay.
4   (1.5)

```
5    DOC:    O:h no. It was only a couple months ago.
6            (1.8)
7    DOC:    So you’re ↑good.
8    PAT:    .tch! y- ‘ave you seen anyting about my sugar?
9            (0.4)
10   DOC:    .tch! let’s see::hh.
11   PAT: -> De:er is a bloodwork that I was gonna te:ll ya I saw it on de
12           television and I wro:te it down to te:ll you. .hh It’s a blood
13           test that they take for your cervik to see if you have
14           canc[er.
15   DOC:        [Oh. You’re wa:y too old to worry about that.
16   PAT:    Really?=
17   DOC:    =Yes.
18   PAT:    heh heh heh heh
19   DOC:    E:ven- even if you (.) were exposed now it’s too late.
20   PAT:    Mmhm
21   DOC:    Yuh- it would never gro:w.
22   PAT:    Oh[: oh.]
23   DOC:      [It ta]kes many many year[s. Okay?]
24   PAT:                               [Oh ↑okay] alright I see I was gonna
25           tell ya y’know [cuz sometime] you see ti[ngs.]
26   DOC:                   [Ye:::ah     ]           [Y- n]o:
27   DOC:    So we haven’t checked your diabetes control in about six months.
28           so I’ll- I’ll put in that order oka:y?
29   PAT:    Alright.
```

In contrast, in line 11 the patient delivers a question with agency framing. The patient begins by reissuing the topic of conversation that the doctor brought up in line 2 – the issue of whether or not the patient needs any blood work done. By including the preface of “I was gonna tell ya”, however, the patient works to distance her question about whether she needs the cervical cancer screening test from the doctor’s initial topic of blood work rather than designing the question to build from that topic. Instead of beginning the question with something like “speaking of blood work…” that takes advantage of the topic to make her question directly relevant, the first-person formulation of “I was gonna tell ya” claims more ownership over the question and distances it from the immediately preceding talk. Additionally, the past tense formulation of the agency framing distances this inquiry from the present time by framing it specifically as something she thought about beforehand. Underscored by her report that she saw it on television and wrote it down to tell the doctor, this question is cast as something she thought of independent from the local context.

Furthermore, consider the patient’s repeat of the agency frame in lines 24-25. At this point, the doctor has informed the patient that she is “way too old to worry” about cervical cancer screening. Though the doctor appears to do so in an effort to ease the patient’s worry (i.e. communicate that she should put it out of her mind, there is no need to fear cervical cancer) by explaining why it isn’t possible for her to suffer from cancer at this point in her life, the extreme formulation of this no-problem response casts the patient’s question as inappropriate and therefore, unnecessary. The patient produces an equally extreme acknowledgement, producing four acknowledgement tokens at the beginning of her utterance in line 24 (oh, okay, alright, and I see) to show that she understands why the test is not necessary for her. However, she then repeats her initial agency frame “I was gonna tell ya” to push back on having her response be seen as built on the doctor’s comment. This is important because bringing unnecessary concerns to the doctor’s attention can be seen as wasting the doctor’s time, and so agreeing with the extreme no-problem response supports the implication that the patient is doing just that. As a result, agency frames work to resist the interpretation that the comments are solely responsive to what the doctor says and acts as a means for the patient to subvert implication that the question was inappropriate and unnecessary and to justify having asking it in the first place.

Although the agency frame in Extract 1 is delivered as a preface to the patient’s question in line 11, the function of this device does not depend on its position within an utterance. This distinguishes these agency frames from similar devices like preliminaries to preliminaries (or pre-pre) that are defined by a specific sequential position. For example, consider Extract 2 below, in which the patient’s wife delivers a pre-pre at the beginning of the visit:

Extract 2 (P105_79yoM_0:00) - saying hi

```
1    DOC:    Hello::, how are you:[:, ]
2    PAT:                         [( )] fine. [Thank you.
3    DOC:                                     [↑Goo:d.
4            (1.2) ((doc closes door))
5    WIF: -> Could I- ask a question
6    DOC:    ↑Mhm
7    WIF: -> My husband told me that he saw (.) Lucy Baron here.
8            (0.4)
9    DOC:    >She's not here< quite yet:. h she gets here (0.2) ((looks at watch))
10           in a little bi:t. hh [You'd] like to say >hi to her?<
11   WIF:                         [(He-)]
12   WIF:    Yeah surely.=
13   DOC:    =°Okay.° I:'ll let her know.
```

In line 5, the patient's wife (who is also a patient of the same geriatrician) produces a pre-pre before voicing her question. According to Schegloff, the pre-pre serves to make room for preliminary talk occurring before the "main event" that the speaker is working up to (Schegloff 1980), and accordingly, the patient's wife begins to set the stage for her question about saying hello to their previous physician who had taken a leave of absence. Though similar in appearance, agency frames are not always found in this position; in this collection, agency framing was found at the beginning (n=32), in the middle (n=19), and at the end of utterances (n=4). Like the second agency frame in lines 24-25 of Extract 1, patients even delivered agency framing after the doctor addressed the concern (n=6), further highlighting its utility in exerting patients' agency and displaying independence from the local context.

One type of pre-pre that bears more relevance to agency framing, however, is the pre-delicate; that is, a type of action projection alerting the recipient that the forthcoming talk is delicate or problematic in some way and is not a simple request for information (Schegloff 1980). As Schegloff notes, when "a question projection is followed by a question, by the question, and that question does not appear to be preliminary to anything further…the projected question is, or is marked as, a delicate one" (pg. 131). Likewise, agency frames in this collection mark patients' concerns as delicate matters that deserve particular attention from the doctor, while questions formulated without agency framing do not. Consider the following example in which the doctor and patient are preparing for the physical exam and the patient asks whether or not he should undress:

Extract 3 (P151_73yoM_17:45) – physical exam

PAT: **Do I need to drop anything?**
DOC: Nope, you can just [sit in the chair there
PAT: [.tch Okay. U::m oh one more thing,

Although getting undressed can be considered an embarrassing topic, the patient does not treat this as a delicate issue. In this case, the patient's question conveys just the opposite; the casual use of whether he should "drop anything" displays the patient's humor towards undressing rather than treating it as a sensitive matter. In contrast, the patient in Extract 1 treats her concerns about cancer screening as delicate by projecting her intention to raise this issue to the doctor. Accordingly, the this elicits a more delicate response from the physician, who attempts to assuage the patient's worry both verbally and physically (patting her arm).

The function of agency framing in emphasizing concerns deserving particular attention from the doctor highlights the second main difference between questions with and without agency framing: the types of information they involve. Questions without agency framing are most often post expansions on doctors' responses to patient questions about diagnosis or treatment. In contrast, questions that are designed with agency framing tend to ask about issues related to proactive patient self-management (e.g. preventive testing, medication management or pain management). For example, consider Extract 4 below:

Extract 4 (P108_79yoF_4:59) – muscle relaxants

PAT: Let's see:.

```
2            (0.5)
3   PAT:     O:h, and then la:st time. You told me that old people (0.2)
4         -> shouldn’t take a lot of chlorzoxazone. (1.2) A:nd I wanted to
5            ask you what’s a lo:t?
6   DOC:     (hh)heh heh hem how much are y(h)ou ta:k(h)ing?=
7   PAT:     =We::ll since you ↑to:ld me tha:t I- buh six months ago:, [I=
8   DOC:                                                               [Mmhm,
9   PAT:     =always break the pills in ha:lf. [(.)I ]probly haven’t tak(h)en
10  DOC:                                       [Mmhm,]
11  PAT:     =more than t(h)en pi(h)ll:s ↑heh heh!
12  DOC:     SO uh- th’ daily basis is the hard thing.
13  PAT:     O:h [I see.]
14  DOC:         [So you] gotta let your kidneys and everything rec(h)over a
15           little bit. [(Mkay?)
16  PAT:                 [Oh I- w- °why: what does it ↑do?
17  DOC:     Oh it affects the: pathway for kidney function. [It chemically=
18  PAT:                                                     [It ↑does?
19  DOC:     =blocks- mhmm.
20  PAT:     Thuh- those muscle relaxants °↑do that?
21  DOC:     Mhm.
22  PAT:     O:h, [I wondered (what)
23  DOC:          [And then you can be dizzy:: an:d uh-unstable on your feet,
24           [so:.
25  PAT:     [O:h, yeah no I rea:lly sto:pped.
26  DOC:     Okay ↑good.
27  PAT:     I di:d.
```

In this example, the agency frame at lines 4 and 5 involves the patient’s proper self-management of her muscle relaxant medication that she takes for her chronic back pain. Given that these medications can have side effects if taken too often – as the patient dutifully reports remembering from her previous visit – the patient’s question comes across as a proactive question related to proper self-care. Likewise, the patient’s question prefaced with agency framing in Extract 1 concerns preventive cancer screening testing that is intended to catch the disease at an early stage, in accordance with the recommended guidelines for preventive health care guidelines for younger adults.

In contrast, the patient’s questions without agency framing build directly on the doctor’s previous comments about treatment and seek clarification. In line 14-15 of Extract 4, the doctor instructs the patient to “let your kidneys and everything recover a little bit” when she takes her muscle relaxant medication to treat her back spasms. The patient then asks for further explanation in line 16 by asking “why what does it do?”. The use of “it” is unspecified, which makes this question hearably built on the previous talk in which “it” is mentioned. Similarly, when the patient reissues this question again at line 20 (those muscle relaxants do that?), the use of the unspecified “that” builds this question as responsive to the previous turn in which the doctor explains what “that” is. Finally, given that the topic of discussion was initially about the quantity of medication (line 5, what’s a lot?) and that the patient has already produced a sequence-closing third and accepted the doctor’s response to her question (line 13, “oh I see”), these questions can be understood as directly responsive to the doctor’s introduction of the medication’s effects as a new topic (line 14) and are thus are less assertive.

Although the concerns indexed in questions with agency framing may not be delicate in terms of severity or urgency, the inclusion of agency framing treats these concerns as delicate in the sense that they involve problems that are of particular importance to the patient. As Schegloff (1980) described, “projecting the question does the work of displaying that a question hearable as subject to delicate treatment once heard, has been so treated on this occasion, by this speaker, for this recipient” (pg 134). Thus, while prescription dosages, refills, and screening tests may not be considered delicate matters in primary care settings, patients and their companions use agency framing to draw the physician’s attention to these concerns.

Together, these differences highlight the role of agency framing in constructing patient engagement in physician-patient interaction. Next, I will focus on the specific ways that agency framing is designed to frame the patient’s question as 1) independently motivated, 2) well-informed, and 3) personally responsible.

3.4.2. Independently motivated

Previous literature about turn-initial elements, like prefaces, have shown that these lexical devices can perform a number of functions; turn-initial elements can index departures from the preceding talk for actions in second position, for example, but can index continuity for actions in first position (Heritage 2013; Heritage et al. 1994). In this collection, far more agency frames were produced in first position (71%) than in second position (29%), and accordingly, the agency frames in the first-position examples seem to index continuity with something the patient had said previously or reported thinking about before the visit. In these cases, agency framing connects the patient's concern to a point in time before the current medical visit, thus framing their inquiry as a continuation of something they had already been contemplating on their own rather than a response to something that was discussed in the visit. In this section, I explore the ways in which patients' design of agency framing helps to constitute their concern as independently motivated rather than responsive to the physician.

A number of features of patients' design in agency framing indicate that the following concern is indeed being raised of their own initiative rather than being responsive to the doctor. First, the design of agency frames often involves past-tense formulations (n=42). Rather than designing agency frames in the present tense, which would place the patient's inquiry in the here-and-now (such as "can I ask you a question?" or "I want to ask you something"), the past tense design of older patients' agency frames links their questions to a point in time that precedes the visit, which thus implies that the action being projected was motivated by the patient's own initiative rather than elicited by the doctor during the interaction.

For example, consider Extract 1. In this example, the doctor has just finished the physical exam and is reviewing the patient's records to determine whether any further blood work should be ordered (and completed) at the end of the visit. While the doctor is looking at the blood test (at the patient’s request, line 8), the patient says that there is “a blood work that I was gonna tell ya” about involving screening for cervical cancer (line 11). The past tense formulation of “I was gonna tell ya” links the patient’s inquiry to a point in time before this visit, and accordingly, in lines 11 and 12 the patient confirms that she “saw it on de television” at home and wrote it down to tell the doctor before coming in. This frames the question as a continuation of what she did at home – seeing something on the television and writing it down to tell the doctor – rather than a question that was prompted by the doctor’s actions (looking up the blood test results).

Similarly, in Extract 4, the patient is reading through her list of updates and concerns to share with the doctor during the problem presentation phase of the visit. While the physical presence of a written list of concerns physically embodies the patient’s initiative in actively participating in her health maintenance, the agency framing allows her to accomplish this verbally. The patient’s agency frame in lines 4-5 is again given in the past tense, which alludes to a time prior to the visit. Like Extract 1, the patient substantiates this past time frame by first referencing her previous visit with the doctor (line 3) and by linking her inquiry to a specific point in time preceding the current visit (six months ago, line 7). Here, not only does the patient show initiative by carefully considering the doctor’s recommendations – taking the doctor’s prior warning about the medication seriously and double checking her understanding – she has “wanted to ask” this question for the past six months. The fact that the patient problematizes the advice the doctor gave (as it was insufficient) even further highlights the function of agency frame as marking the patient’s concern as a continuation of something that she has thought about independently.

Although fewer cases of agency framing occurred in second position, these examples underscore the function of agency framing as a tool to display patients’ independent competence in managing medical issues. In cases where the patient's question appears in second position, agency framing exerts agency over topics raised by the doctor. This portrays the patient's independent motivation to discuss concerns that arise before they have a chance to introduce them. For example, consider Extract 5:

Extract 5 (P107_80yoF_14:15) – low B12 results

```
1    DOC:    Suh- your bee twelve is pretty lo:w no:rmal.=
2    PAT: -> =Oh yeah that's: (.) the other thing I wanted to talk to you
3            about. [Thos(h)e] those re- those result[s.
4    DOC:           [Mmhm,   ]                       [Mmhm,
5            (0.2)
6    PAT:    What uh:: that one that they h(h)ighlighted ju know that got me
7            c- uh: contacting you and I- I forgot to re look it up when I
8            (0.2) was coming i:n I- everything eugh- I got the feeling that
9            fru- I mean I kno:w from your response that you didn't think
10           there was any pro:b[lem (      )
11   DOC:                       [No: I- I'd like to give you a bee twelve
12           shot no:w, (1.0) n' then every time you come see me we'll do:
13           one. (.) And then you can take bee twelve over the counter if
14           you want(h). .hhhh It's no:rmal but it's low normal. I like
15           high. [Cuz ih- it can't hurt a:nd it might help.
16   PAT:          [That's fine with me I-
17   PAT:    I'll go get bee twelve that's: not a problem.=
18   DOC:    =Oka:y, and then your- your sugar (eight)- you're kind of [like=
19   PAT:                                                              [Yeah
20   DOC:    =glucose intolerant (.) but I wouldn't want to label you
21           diabetic, okay?
21   PAT:    °Kay
22   DOC:    An:d u:m your kidney function has been the same as long I've
23           known you,
24   PAT:    So it's okay as far as y'know taking a few uh: uh[ alev]e=
25   DOC:                                                     [Ye:ah]
26   PAT:    =sc[rew it up probably   ]
27   DOC:       [Every once in a while] No.
28           (1.0)
29   DOC:    tch! u::m and that's ↑it
```

Here, the doctor is again reviewing past blood work as she wraps up the visit. In line 1, she produces an assessment about the patient's results, saying that "your bee twelve is pretty low normal". From the patient's perspective, the characterization of her Vitamin B12 as "low normal" is a bit unclear (since the usual "normal" level of B12 is not common patient knowledge), and accordingly, she seeks clarification in the turns that follow. However, rather than asking for further explanation by designing her question as responsive to (and a continuation of) the doctor's assessment (e.g. "what does that mean?" or "what's low normal?") this patient uses agency framing to distance her question from the local context. Her past tense formulation of "that's the other thing I wanted to talk to you about" (line 2) reaches back to a time before the visit, which she then substantiates in lines 6-10 when she mentions her initial receipt of these results and subsequent email contact with the doctor to ask about them. Since this patient is asking about the results again despite the fact that she has already communicated with the doctor regarding this issue via email, we can assume that the patient has not yet understood the meaning of her results. This implies that she may have been thinking about this question since the time when she first received the results, thus making this question a continuation of her initial inquiry. Furthermore, the patient also mentions that she had initiated this communication (as evidenced by her comment that it "got me c- uh: contacting you"), which shows that she was in fact the first to notice this issue even though the doctor initiated this topic in the current interaction. Consequently, her question about "those results" (line 3) is framed as independently conceived despite the fact that concerns about her "low normal" B12 levels were raised by the doctor.

This pattern is evident again in Extract 6. In this example, the patient is presenting a concern about a wound on his leg that he incurred sailing four days earlier. He relates a lengthy story in which he alludes to a concern about the polluted water in the bay where he sails affecting his injury, but before he reaches the actual question, the geriatrician produces an insert question: "so this didn't happen in the water it happened on land but you've been in the water" (lines 9-10). The geriatrician takes up the water pollution issue and topicalizes this aspect of the story as the patient's main concern about his injury. After a delay and the beginning of a "no" answer in line 12, the patient responds with a partial repeat (it happened on land), and then works to redirect the topic of the conversation back to what he originally had in mind: a question about how best to bandage similar injuries in the future. Though other features, like the partial repeat at line 12 (rather than providing a yes or no response) assert the independent nature of the patient's response, the agency frame at line 17 also serves as a means to distance the patient's question from the one the doctor initiates at line 9.

Extract 6 (P110_90yoM_3:50) – leg bandage

1 DOC: Okay, what el:se?
2 PAT: Well, (2.0) I- where I sail I have to (1.0) u- back the boat
3 down the: ra:mp in the marina del re:y…
4 --
5 ((Next 1:15 cut – patient continues story about hurting his leg and
6 having trouble with bleeding because of the aspirin he takes, and hints
7 at a worry about the pollution in the water affecting his injury))
8 --
7 DOC: Okay.
8 PAT: Uh:
9 DOC: So this didn't happen i:n the water.=it happened on la:nd but
10 you've been in the water.
11 (0.5)
12 PAT: Nuh- it happened on la:nd uh- uh- yihknow four days earlier,
13 DOC: Okay.
14 PAT: But it bled for- (0.2) for two or three of those days (1.2)
15 little bits y'know it was bandaged but they w- w'd (0.2) s- soak
16 through with (blood) (1.2) u:h ih- it seems to have (0.8)
17 -> stopped blee:ding now but what **I wanted to a:sk you** is (0.8) u:h
18 since something like that's likely to happen agai:n (1.0) ho-
19 what wouldju recommend in terms of (1.0) uh- uh- uh of uh of
20 bandaji:n or leaving it open to the ai:r? I don't want to have
21 blood trickling [down (0.5) my] le:g, (0.2) .hh starbucks might=
22 DOC: [hm hm hm hm!]
23 PAT: =say it doesn't meet their criteria for admis[sion.
24 DOC: [hhhm hm hm tch I think
25 bandanging it is appropriate. (0.2) Uh::, (1.5) y- maybe when
26 you go to bed at night a very light bandag(h):e. so that it gets
27 some air. B't that's okay. Looks like it's healing we:ll no:w.
28 (1.0)
29 PAT: Uh:- well I thought th't was bleeding a little bit yesterday but
30 then: maybe (0.2) that was j's leftover from: uh
31 (1.0)
31 DOC: Mhm,
32 PAT: the day befo:re.
33 DOC: And is it four days ↑ol:d?
34 (1.0)
35 PAT: Yeah.
36 DOC: °Okay.° And it's not painful?

```
37   PAT:    Yes that was painful.
38   DOC:    Okay. There's still some (.) little like blister underneath.
```

Like the other excerpts, the patient formulates his agency frame in the past tense, producing “what I wanted to ask you is” at line 17. Framing his question in this manner resists the doctor’s implication that the water pollution was his main concern, and instead links the question to a time in the past (like the four days preceding the visit, as he mentions in line 12). Furthermore, the agency framing is preceded by a contrast marker, “but” that supports the interpretation of the agency frame as something that is not continuous with the doctor’s line of thinking. This both distances the patient’s question from the doctor’s inquiry at line 9 and connects it instead to a time when he was thinking about this issue on his own.

Finally, the function of agency framing in depicting patients’ independent motivation for raising topics of concern is also underscored by features that are not visible in the transcripts of these excerpts. In many of the visits with agency framing, for instance, patients also embody this purpose by referring to a physical list of concerns that they prepared before the visit began. Additionally, the absence of sequence-initiating ‘so’ prefaces also supports the idea that concerns presented with agency framing are meant to be viewed as originating outside of the current interaction with the physician. Previous research has demonstrated that ‘so’-prefaced turns indicate that an upcoming action has been delayed or pending rather than being contingent on the immediately preceding talk, and that ‘so’-prefaces also help to reopen action trajectories that have already been brought to a close (Bolden 2009). Given that agency frames are used in sequence-initiating environments where patients display that they have been waiting to raise the concern at hand, the use of ‘so’-prefaces might be appropriate in this context. However, ‘so’-prefaces are largely absent in this collection, supporting the idea that questions produced with agency framing are not intended to be heard as pending within the current interaction, but as emerging completely independently before the interaction began.

3.4.3. Well-informed

Previous research shows that patients often make requests using the low entitlement “I wonder if” format (Curl and Drew 2008), but rather than using question design to construct themselves as lacking entitlement, questions designed with agency framing served the opposite purpose; these questions infrequently used the “I wonder if” format (18%) and were often accompanied by accounts that justified the sensibility of the request. Together, these features of agency framing work to portray the patient as entitled to make these requests in service of fulfilling the expectations of a “good” patient who proactively manages their health while also respecting medical authority.

For example, consider Extract 7 below. This patient requests a prescription for a stronger pain medication in lines 8-9, which is delivered in response to the doctor’s question about whether the patient has increased the dose of her current medication as they discussed during the last visit. Rather than responding directly to the doctor’s question (which would mean disclosing the fact that she did not do what they discussed), the patient treats the doctor’s question as a proposal by responding “I could do that” in line 4. Thus, she does not conform to the design of the doctor’s question – which seeks a yes or no response – and resists the terms of the question. This is then followed by an agency frame, which further distances the patient’s question from what the doctor asked by framing it as something she had been thinking about asking the doctor in advance of the visit. Next, she gives an account for the impending request by reporting what she knows about the medication – “I don’t know how strong the medicine is” and “maybe it’s just a light painkiller”. Here, the agency frame helps the patient to gloss over her non-adherence to the previous recommendation and instead justify that her request for a stronger prescription was informed and done with good reason.

Extract 7 (P131_98yoF_6:00) – stronger pain medication

```
1    DOC:    How- how bout the pai:n in the knee. Last time we talked about
2            increasing the the amount of pain pills you take in a day, did
3            you do that?
4    PAT:    Well I- I could do that. I was thinking it was one of the things
5            I was going to talk with you about [(.) .h ] and I don’t know=
6    DOC:                                       [uh huh,]
7    PAT:    =how strong the medicine is that (again) it may not uh- uh maybe
8            it’s just a light uh: (.) pain killer maybe I could have
9            something a little stronger.
10   DOC:    How many do:: you take a day?
11   PAT:    ((looks at caregiver)) Th[re- three,
12   CAR:                             [Uh::m three times.
13   DOC:    Okay=
14   CAR:    =Three [times.
15   DOC:           [.h When you take it does it (.) help? Like is is the
16           problem that it wears off quickly? Or is the problem that (.)
17           it’s just not stro[ng enough.]
18   CAR:                      [I think it] helps. It helps her.=
19   PAT:    =Yes I [think] it helps t[oo.  ] ((some other overlap??))
20   CAR:           [Yeah.]           [Yeah.]
21   DOC:           [Okay.]           [So   ] maybe it just wears off
22           [(.) .hh] before the next dose.
21   CAR:    [Uh huh ]
22   CAR:    Yeah.
24   DOC:    So it’s oka::y to take
```

In Extract 7, that patient portrays herself as well-informed to resist the potential interpretation that she was not complying with the doctor’s prior recommendations. However, patients also used agency framing to justify making an atypical request. For example, consider Extract 8 below. In this case, the patient’s request for a medication refill is slightly unusual because she has not actually run out of her medication yet, and because she wants her prescription on paper rather than the standard electronic prescription. She begins by explaining what she knows about her condition, the medication, how it should be taken, and how much it costs, followed by the action projecting preface and request for a refill in line 26-27. The request is followed by a further account that demonstrates her knowledge of how the health care system works, thus supporting her need for the paper prescription.

Extract 8 (P116_15:30) – eye drops refill

```
1    PAT:   °.h okay° And the:n (0.8) .tch my other question for you. is, I-
2           I was told yea:::rs and years ago by an ophthalmologist .hh that
3           I (.) had (.) dry eyes >or whatever<=I don't know the technical
4           word and that I should take restasis. [I don't know how] to=
5    DOC:                                         [ ((inaudible))  ]
6    PAT:   =verify if that was [accurate] that I really [do or don't or]=
7    DOC:                       [(okay.) ]               [(yeah, yeah)  ]
8    PAT:   =that I really need it or I don't need it ↑but [I've been] .hh=
9    DOC:                                                  [Okay,    ]
10   PAT:   =taking a small dose of restasis=[I brought] the top of my bo:x=
11   DOC:                                    [Okay,    ]
12   PAT:   =for you? .hh my- (0.5) I still have one more bo:x [but
13   DOC:                                                      [Do you feel
14          like it's helping?
15   PAT:   It does: keep my- >cuz I wear lenses<
16   DOC:   Uh huh,
17   PAT:   .tch So it prevents the dry: ey:e fee:l.
18   DOC:   Okay,
19   PAT:   And I do it- you have to do it before you put'cher lenses
20          [in.=so (0.5) ]I brought this in because I was gonna request a=
21   DOC:   [Yeah. Uh huh,]
22   PAT:   =renewal cuz this is no more. It needs a new [prescripti]on=
23   DOC:                                                [Yeah okay,]
24   PAT:   =but I don't need it now cuz I have one more box=[it's very]=
25   DOC:                                                    [↑Okay.   ]
26   PAT:   =[<expensive>.] .hh so I w'd- was wondering if I could get like=
27   DOC:    [Yeah, yeah. ]
28   PAT:   =a written prescription (.) for thi- for (this you when) I take
29          it in: like it's- whenever the bo- the new bo:x is go:ne, .hh
30          cuz if you do it now: through thee (0.2) .h email or th-
31          >whatever it i:s<, what they do is they fill it immediately.=
32   DOC:   =What I can do is I can just do a printou:t? as opposed to uh:-
33          (.) electron[ically.]
34   PAT:               [Ri:ght.] And that way [when I need it I'll go in=
35   DOC:                                      [°So I'll just a:dd u::m°
36   PAT:   =with it.
```

Although asking questions in general can indicate a patient's desire for information or services – regardless of whether an agency frame is present – questions that include agency framing create opportunities for patients to demonstrate foresight in the visit. Accordingly, patients seem to fit their questions to this function by asking questions about concerns that are future-oriented when using agency framing. In Extract 8 above, the agency frame in line 26 is again delivered in past tense – “I was wondering” – which casts this request as something she thought through in advance of the visit. By reporting the background information that accounts for her request, the patient demonstrates more precisely *what* she thought about in advance. This highlights the patient’s knowledgeability about her dry eye problem, but also demonstrates to the doctor that she has foresight in managing her symptoms; the request for a paper refill may not be immediately necessary, but making the request while she is already in the office will prevent the patient from a dry eye flare up that could result from being caught without any medication left. Similarly, in Extract 6 the patient follows his agency frame in line 17 with the account that “since something like that’s likely to happen again”. Thus, the patient demonstrates that he is thinking ahead and trying to prepare for possible future incidents when the doctor will not be present to assist him. Likewise, the patient in Extract 1 demonstrates foresight in managing her health by giving an account for what prompted her question; she not only thought of the question and wanted to talk to the doctor about it, but she went a step further and wrote it down as well. Additionally, the problem she is asking about is cancer screening, which is in itself an issue that involves foresight because it is part of the regular preventive screening tests that aim to detect cancer early when done regularly.

The utility of agency framing in exhibiting patients’ proactive health management is further underscored by the fact that patients often asked about end-of-life concerns – a topic that quite literally involves proactive health planning. For example, consider the Extract 9:

Extract 9 (P150_79yoF_18:20) - medical aid in dying

```
1    DOC:    And when we >talked about it though< it wasn't about driving a
2            car it was more related [to (how)] how- how important=
3    COM:                            [Yeah    ]
4    DOC:    =[reading is [()    ]
```

```
5     COM:      [I’m just th[inking]
6     PAT:                   [ Yes, ]coming and going when [I want and not=
7     DOC:                                                  [Yes. Right. Yeah.
8     PAT:     =having to ASK [(.) .hh] for help. [U:m  ]
9     DOC:                    [Right. ]           [Right]
10    COM:                                        [Sure. Yeah. °Well° (0.2) so
11             far that's worked out pretty well, (but the) reading thing
12             would be ((stop gesture?))
13    PAT:     I um (0.2) .hh (0.4) have mentioned to: a number of friends
14    DOC:     Mhm
15    PAT:     uh: of around my a:ge, .h my: interest in thee (0.8)
16             assisted [(.) suicide,
17    DOC:              [Mhm
18    COM:              [Assisted check out.
19    PAT:     .hh an:d um: (0.8) .tch probably ninety percent of them say:,
20             .h oh: me too tell me about that.
21    DOC:     Mmhm, [mhm]  ((nodding))
22    PAT:           [Um ]I’ve wanted to find out about that.
23    DOC:     Mmhm, mh[m  ((nodding))
24    PAT:             [U::m (0.4) it's ↑very interesti(h)n(h)g(h).
25    DOC:     Right, and- and I know you've read up on it and you're:
26             [somewhat] familiar with it, .h so- we do have that process=
27    PAT:     [Yes.    ]
28    DOC:     =here as I men[tioned last time, .h an:d uh I’ve- nuh- not=
29    PAT:                   [.hh Yes. Yes °I know, yeah°
30    DOC:     =something that I've been involved in personally? just >because
31             of the way< my practice is set up right now,[.h ]u:m but (.) if=
32    PAT:                                                 [Mhm]
33    DOC:     =that's a discussion you want (.) to ever carry further, th- we
34             ha:ve [th’ processes] and everything [here at clinic. ( )
35    PAT:           [Yes::.       ]                [°Yeah.° I don't think I
36             would qualify. be[cause I don't think macular=
37    COM:                      [No:: (probably no)
38    PAT:     =degen(h)era(h)tion is a .h qu(h)alifying disorder.
39    DOC:     Correct. It's not. [But,] >if you want< more information about=
40    PAT:                        [Yes.]
41    DOC:     =tha:t or other things about that [we ]can certainly have you=
42    PAT:                                       [Mhm]
43    DOC:     =talk with- [with the pe]ople that are [heading that option.
44    PAT:                 [.tch Okay. ]              [Yeah. No, not right now,
45             so.[(0.4)] I'm hoping to (.) live until January.
46    DOC:        [°okay°]
```

The patient in this example is in relatively good health, but is frustrated with her worsening eyesight and its impact on her long-term quality of life. She raises the possibility of medical aid in dying in line 16, which she has spoken to the doctor about before. In this case, the doctor echoes the patient’s status as someone who is knowledgeable by mentioning the patient’s familiarity with this issue in line 25 and referencing their previous discussion about the topic in line 28. The patient then demonstrates her knowledge of medical aid in dying in lines 35-38 by articulating a more nuanced understanding of the criteria this option requires. By the end of this sequence, the we see just how informed and proactive the patient is; when the doctor offers to connect her to people who could discuss medical aid in dying with her further, she turns down the offer because she is not interested in pursuing that option just yet.

3.4.4. Engagement and responsibility

Agency framing demonstrates patients' engagement in health care by emphasizing their knowledgeability and foresight, particularly in relation to chronic ailments. Acute problems cannot always be anticipated, and as research has shown, patients actively try to demonstrate that they just "noticed" such problems incidentally rather than keeping an eye out for them (Halkowski 2006). For chronic ailments, however, patients are encouraged to actively monitor their symptoms in order to treat them successfully (Bodenheimer et al. 2002), and including agency framing highlights the fact that the patient is doing just that. Across the collection, questions with agency framing involved either existing, chronic concerns or preventive health maintenance issues. The most common concern was prescription management for existing problems (21%), followed by chronic pain (15%), screening tests or test results (10%), and end-of-life planning (10%). Even concerns in this collection that may not appear to be chronic on the surface, such as the patient's leg wound in Extract 6, involve recurring problems; while cuts and scrapes are acute problems, the leg wound is a recurring issue because the patient takes a blood thinning medication that makes it difficult for any of his wounds to heal. Thus, like a chronic condition (e.g. Extracts 4, 5, 7 and 8) or a routine health maintenance task (Extract 1), this patient also orients to the need for anticipating potential future problems related to this issue.

Additionally, patients demonstrate personal responsibility by using agency framing to inquire about non-urgent problems or issues that are not essential to their routine health maintenance. Medical research emphasizes the importance of patient compliance (Lutfey and Wishner 1999) and as such, patients may try to display themselves as compliant, responsible and engaged patients during interactions with physicians. Using agency framing for urgent problems or for problems that have health consequences if left unchecked, on the other hand, would undercut the utility of agency framing as a means to demonstrate foresight and responsibility. For example, asking a question like “I was gonna ask you, how do I treat my diabetes?” would frame the patient as someone who has allowed his/her condition to remain untreated and incapable of following through with the recommended treatment to maintain good health. In contrast, the actual concerns that patients asked about when using agency framing dealt with issues that went beyond the ‘call of duty’ of their medical care. In Extract 1, the patient’s diligence in asking about cancer screening is not actually necessary. Similarly, in Extract 8 the patient was requesting a written prescription for her eye drop medication before she actually runs out. She does not actually need the prescription right away, but is staying on top of maintaining the treatment for her chronic dry eye seamlessly, without breaks due to missed prescription refills that could be avoided. Questions around end-of-life concerns like those in Extract 9 also do this by asking about how to plan ahead for future eventualities.

Doctors’ responses to agency frames also reflect their relevance to non-urgent problems given that such requests were either granted or were given a “no problem” response. In Extract 5 the doctor does both, first providing a no-problem response and later upgrading her treatment of the problem to a minor concern. In lines 9-10, the patient states that the doctor’s initial response (which occurred prior to this visit) was that there was no problem with her results. Additionally, the patient even amplifies the no-problem response with the negative polarity item “any” to indicate that it was not just that there wasn’t *a* problem, but there wasn’t *any* problem. After the patient’s agency frame (lines 2-3) and reissued concern about the test results (lines 6-10), however, the doctor upgrades the prior no-problem treatment of the results to a minor problem and offers an equally minor treatment option that “can’t hurt” and “might help” (lines 11-15). Like Extract 5, other instances of agency framing also involved concerns that had been discussed previously (e.g. Extracts 4, 7 and 9), showing that even though these may problems may not be serious, they are of particular concern to the patient and may warrant more attention from the doctor.

Finally, agency framing helps to frame patients as responsible by creating an opportunity for them to act responsibly in the doctor’s office. The past tense formulation of action projecting prefaces shows that the patient was thinking about these issues on their own in advance of the visit, and so the very act of following through with the action they are projecting displays responsibility. For example, return to Extract 1. By indicating that she has already taken note of potentially important information related to regular health maintenance that she “was gonna tell” the doctor about, she shows that she is being responsible for her health by actually saying what she was planning to tell the doctor in the visit.

3.5. DISCUSSION

Many aspects of interaction in primary care have changed over the past century. Visits are shorter and, for the most part, are no longer conducted at patients’ homes. Technology and consumerism are ever more present in medicine, and this too affects the way physicians and patients interact with one another. It is the increasing acceptance of patient-centered care models, however, that has perhaps influenced current values around the roles and obligations of patients and physicians the most. Yet, the structure of medical visits has not changed, making it challenging for patients to fulfill shifting expectations of patient engagement in an institution that is rooted in paternalism. Patients are still sensitive to the power that physicians possess as authority figures, and as such they must somehow negotiate the balance between traditional deference and modern autonomy in managing their health. As this article has shown, using agency framing when asking questions is one interactional resource that patients use to try and accomplish this task.

The older patients in this study used agency framing to portray their concerns as independent, well-informed, and responsible, and primarily did so when addressing problems that were chronic and non-urgent. Though this device seems to have particular relevance to the anticipation of future problems, it appears to be relatively versatile in other ways. Patients used agency framing in varying positions within turns and within sequences to exert varying degrees of epistemic authority over a topic, and so too did their companions; agency framing was also employed by companions to convey their own engagement with the patient's medical care, or to underscore the patient's engagement (e.g. "she wanted to ask about that"). Additionally, while this collection focused on question design, there were a few instances where patients applied agency framing to other actions such as informing or giving an account. While these examples were not the focus of this article, this could point to the broader utility of agency framing beyond the specific setting described here. Future research should examine the role of agency framing in other contexts to explore its potential applications further.

Still, there are a few reasons why agency framing bears particular relevance among older patients and why this device may be more visible in the context of geriatrics. First, geriatrics appointments in the United States are typically longer than appointments in internal or family medicine, which may allow more time for older patients to initiate actions such as asking questions – and accordingly, to use agency framing. Second, older patients tend to experience more chronic health problems that require self-management at home, so the context in which agency frames are delivered (i.e. in relation to chronic or non-urgent problems) may be relatively more common among geriatrics patients than among those who are younger. The key reason why older patients have more cause to demonstrate their willingness and ability to cope with medical problems, however, is maintaining independence. At some point, there may come a time when an older patient's declining health could prohibit them from continuing to live life as they have been for many years, and geriatricians are responsible for observing when such changes may need to be addressed (e.g. recommending that a patient no longer drive anymore). It may be gradual, or it may be sudden, but this constant possibility makes older patients' demonstration of responsible self-management important for more than just being perceived as a good patient; it could also mean being able to live an independent life.

Regardless of age, however, physicians should take notice of concerns that patients raise with agency framing. Patients can always opt to ask questions without using agency framing, but the choice to do so speaks to their perceptions of particular health concerns as well as their role physician-patient interaction. In this study, patients used agency framing to treat certain concerns as delicate, not due to their urgency or severity but because of their importance to individual patients. In many cases, agency framing even signaled a patient's continuing concern over a topic that had already been discussed in previous visits. Doctors should thus consider responding thoughtfully to questions that are designed with agency framing, and perhaps expect to revisit these issues again in the future.

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CHAPTER 4

EMPATHIC VALIDATION: AN APPROACH TO CLINICAL EMPATHY FOR PROBLEMS WITH UNCERTAIN SOLUTIONS

4.1. INTRODUCTION

Interest in understanding empathy and compassion in clinical contexts has grown in recent years, with some scholars even delineating a new branch of science dedicated to its study (Trzeciak, Mazzarelli, and Booker 2019). In conducting an analysis of empathy, however, it is first necessary to define what exactly constitutes empathy in clinical encounters. The term "empathy" is generally defined as: the ability to understand and share the feelings of another person. Research about recommended approaches to clinical empathy reflects this meaning and highlights the importance of the doctor's ability to explicitly acknowledge the patient's feelings to make them feel understood (Coulehan et al. 2001; Suchman et al. 1997). Much research has reported the benefits of clinical empathy, though scholars also agree that its conceptualization and empirical study is challenging (Frankel 2009).

A recurring issue in this literature is the trouble with identifying appropriate "empathic opportunities", particularly because patients rarely verbalize their emotions directly and spontaneously (Suchman et al. 1997). This is problematic for physicians because a primary way that moments of empathic communication are elicited is "when persons report first-hand experiences of any great intensity (involving, for example, pleasure, pain, joy or sorrow), they obligate others to join with them in their evaluation, to affirm the nature of the experience and its meaning, and to affiliate with the stance of the experiencer toward them" (Heritage 2011, p. 160). When expressions of emotion are more indirect, as in medical contexts, it is less clear when exactly doctors may be obligated to communicate empathically with their patients. In this article, I aim to address these concerns by conceptualizing one type of empathy, which I term *empathic validation*. I show that providing this expression of empathy does not depend on the patient's ability to create an empathic opportunity and examine the context in which doctors provide validations. In particular, I find that doctors commonly provide empathic validation when there is no medical solution for the patient's concern.

Doctors have historically been trained to express their clinical opinions with a manner of certitude – regardless of any feelings of doubt or tentativeness about the decision at hand (Fox 1957). Yet as Renée Fox described, "there are many times when his [sic] most vigorous efforts to understand illness and to rectify its consequences may be of no avail" (pg 208), in which case "he [sic] is sometimes inclined to react subjectively to the uncertain features of cases he [sic] cannot bring to a satisfactory conclusion" (pg 232). These situations are particularly common among the elderly, whose health problems often cannot be cured and rarely have guidelines to help inform decisions about what should be done to help (Boyd et al. 2005). I argue that in these circumstances, doctors can express empathic validation as a last resort for problems that have no clinical solution. I also discuss what activities are accomplished through the expression of empathic validation and examine how the design of the empathy impacts its effectiveness. Finally, I highlight some of the differences between empathic validations delivered to men and women patients.

4.2. BACKGROUND

Medical and public policy research has advocated that empathy and compassion is lacking in our health care system, and that both patients and physicians are negatively affected by this compassion crisis (Trzeciak et al. 2019). While scholars recommend "the development of systematic approaches to help health care professionals improve the skills required for compassionate care" (Lown, Rosen, and Marttila 2011, pg. 1772), reaching this goal has been challenging for a number of reasons.

The primary challenge is conceptual; empathy is often considered a feeling or mental state (Hoffman 2000), making it difficult to consistently determine when someone is expressing empathy and what expressions of empathy should look like in verbal or non-verbal terms. The boundaries around what constitutes empathy in interaction is further complicated by the range of related emotional responses that often occur together, such as sympathy, emotional support, caring or concern (Pudlinski 2005). Within existing conceptualizations of empathy, scholars have also documented the range of resources that people can draw on to express empathy (Kupetz 2014) and have recognized variations in the degree of empathy that different responses provide (Heritage 2011). Much empirical research on empathy in medicine draws on post hoc quantitative methods that only assess perceptions of empathy (Pedersen 2009), and while such approaches are useful in their own right, these methods cannot address the conceptual challenges about precisely what "counts" as empathy or how, when, and to whom doctors should express it.

Although no unanimous definition of empathy exists, interaction scholars have attempted to address these concerns by focusing not on the affective state of "empathy" that a person may experience, but by using qualitative methods to unpack the meaning – and practical function – of empathy based on detailed investigation of participants' actual conduct (Hepburn and Potter 2007; Ruusuvuori 2005). Many interactional studies of empathy have approached this issue by focusing on "empathic opportunities", or moments 'in which a patient directly [expresses] an emotion and [creates] the opportunity for an empathic response, in which the physician explicitly [acknowledges] that emotion' (Suchman et al. 1997, p. 679). However, this framework is limited in the sense that it approaches empathy as only a means to respond to opportunities that patients create and does not capture the broader social functions of empathy in medicine. In response, conversation analysts have demonstrated some of the ways that expressing empathy can assist doctors in achieving clinical goals. For example, Ford, Hepburn and Parry (2019) showed that displays of empathy allow doctors to bridge the gap between doctor and patient when their perspectives are at odds, and highlighted several different contexts in which this function can be applied (e.g. when patients are skeptical of the medical perspective or when patients have unrealistic expectations of treatment).

The benefit of this approach is that findings speak more directly to *when* doctors can display empathy and how doing so in the right contexts can facilitate clinical work. Yet, given that successful training in empathic skill can take physicians many hours to learn (Bonvicini et al. 2009), more research that addresses exactly *how* empathy should be expressed is warranted. A more precise vocabulary around specific expressions of empathy – such as reassurance, concern, or validation – could help clarify how doctors should design their expressions of empathy without compromising gains that scholars have made in understanding the utility of empathy in certain contexts.

To address this issue, in this article I use a framework similar to that of Ford, Hepburn and Parry (2019) to conceptualize empathy but approach my analysis from a different angle; rather than focusing on the function of empathy and then identifying particular contexts in which it is useful, I first conceptualize one specific type of empathic expression – which I term empathic validation – and subsequently explain the context in which it appears as well as its function in that context. In keeping with previous research highlighting the importance of understanding patient responses to empathy in determining whether a particular expression is successful (Coulehan et al. 2001; Frankel 2009; Wynn and Wynn 2006), I analyze patients' responses to empathic validations in order to assess what the appropriate form of validations may be. Additionally, I build on previous literature about expressions of empathy in interaction by highlighting *who* receives empathic validations; in particular, I focus on the differences between empathic validations provided to men and women with respect to frequency, types of validations, and patients' responses to those validations.

4.3. METHODS

This article draws on a corpus of 52 video recordings of patient visits in a geriatrics clinic located in a large urban area of the United States. Patients were eligible to participate if they were attending an appointment with a participating physician, were 65 years of age or older, and were able to provide informed consent. Videos include four different board-certified geriatricians with varying levels of experience and were collected between August 2016 and September 2017. All aspects of this study were approved by the institution's IRB and all participants provided written informed consent.

Data were analyzed using conversation analysis. Conversation analysis literature on empathy has documented various formats that empathy can take (Beach and Dixson 2001; Hepburn and Potter 2007; Heritage 2011; Pudlinski 2005), though there is no unanimous agreement about how empathy should be defined. This article focuses on one particular expression of empathy termed *empathic validation.* Both the author and a research assistant reviewed the entire data set to identify all instances in which doctors expressed *empathic validation,* defined as any phrase that positions the doctor as validating or reaffirming the patient's feelings or experiences (e.g. that's frustrating). Instances in which doctors expressed empathic validation to patients' companions were also included. To maintain cohesiveness within the collection, responses that primarily addressed medical correctness (e.g. that's correct, twice a day good) and vague expressions of empathy (e.g. aww) were excluded. This collection includes a total of 129 cases.

The 129 cases in this collection were then examined closely and analyzed with particular attention to the design and function of empathic validation in relation to where each case occurred in the local sequential context and within the overall interaction. Given that medical visits always include a presentation of the patient's problem(s) – and that these problems are usually the reason for the interaction – this chapter will focus primarily on empathic validation in response to patients' problems rather than instances in response to good news (e.g. that sounds incredible). In this article, I examine when empathy – in the form of empathic validation – is provided and discuss when it tends to be successful in medical interactions. I also examine qualitative and quantitative differences between expressions of empathic validation to men and women, and explore the implications of these disparities.

4.4. ANALYSIS

As seen in Table 1, data represented patients (66% female) with a mean age of 81 who attended visits alone (60%) more often than with companion(s) present. Patients primarily self-identified as white/Caucasian (66%).

Table 1
Characteristics of study visits

Characteristic	Mean (range)	N (percentage)
Patient Age	81 (68-98)	
Patient Sex		
Male		18 (34%)
Female		35 (66%)
Patient Race/Ethnicity		
White/Caucasian		35 (66%)

Black/African American	11 (21%)
Asian	3 (6%)
Other	4 (8%)
Patient visits with companions present	
Patient alone	32 (60%)
Companions present	21 (40%)
Patient visits by sex and presence of companions	
Men alone	13 (25%)
Men with companions	5 (9%)
Women alone	19 (36%)
Women with companions	16 (30%)

4.4.1. What is empathic validation?

There are many ways that people can convey to others that they understand them: answering a question, offering someone a ride before they have to ask for one, or agreeing with an opinion. Empathy is another important means for people to demonstrate mutual understanding, and in the context of medicine where personal concerns must be expressed and addressed within a short period of time, this aspect of communication is especially critical. Many scholars, clinicians and advocates agree that medical professionals should express more empathy, but research in this area still lacks a common nomenclature that clearly defines specific actions that "count" as empathy (Frankel 2009; Trzeciak et al. 2019). This article takes steps towards developing a more consistent understanding of empathy in interaction by focusing on one type of expression: empathic validation.

One important aspect of empathic validation is that it must be attentive to the other person's experience; if empathy is generally defined as the ability to understand and share the feelings of another person, simple repeats of what was already said or overly general responses (e.g. yeah, I understand) demonstrate only acknowledgement and not shared understanding. Vocalizing some aspect of the patient's experience, however, does communicate the shared understanding that empathy entails – especially when the validation extends beyond what the patient has already shared. For example, consider Extract 1:

Extract 1 (P146_71yoM_11:19)

1 DOC: °Okay.° .h Other question:s, concer:ns today?
2 PAT: .hhh hhhhhhh .tch I'm getting wea:ker (.) and I'm lo:sing my
3 ba:lance more often.
4 DOC: °Mhm° any fa:lls recently?
5 (0.5)
6 PAT: Yea::h a couple, .h and I- once in a while I lose my balance when
7 I tur:n (0.8) and I start to fall. That doesn't disturb me much.
8 (.) because I can catch myself .h but twi:ce (0.2) .h I was
9 suddenly (0.5) o:n the floor.
10 DOC: Mmm.
11 (1.2) ((doctor finishes typing and turns to patient))
12 PAT: And that was stra::nge.
13 (.)
14 DOC: Ri:ght. .h An:d u:m (.) do you remember what ↑happened before you
15 fe:ll or:=
16 PAT: =Oh (I went and) I bent over to pick something u:p (0.2) and then
17 I musta just gone (0.8) boom and I landed on (.) (th') r:ight
18 hip_ (0.5) was sor:e for a couple uh da:ys.
19 DOC: °Okay.° .h u:m:: >any other trauma< from any of these falls?
20 [( )]
21 PAT: [No:.] Noth(h)in(h)g (h)of (h)an(h)y
22 DOC: °Okay.°
23 PAT: Other than feeling like a foo:l.
24 DOC: Mm. Yeah falling is: (.) distressing. Right? [It's not something=
25 PAT: [Yea:h.
26 DOC: =we do when we're younger, [.hh
27 PAT: [Ri:ght.
28 DOC: and we get- we worried about when we do it when we're older.
29 .tchh Um (.) now we've have you do physical therapy that's come
30 to your hous:e before. [Correct? No?] .h What about physical=
31 PAT: [((shakes head))]
32 DOC: =therapy at the outpatient [physical therapy on Alde]rmans.
33 PAT: [((shakes head no again))]
34 DOC: .h Is that something you'd be able to do:?
35 PAT: What can they do: at the house.

In this case, the patient minimizes the damage from his previous fall in line 23 and says that there was no trauma other than feeling like a fool. The doctor expands on what the patient feels by adding that falling is distressing (line 24) and causes worry when we're older (line 28), showcasing the "empathic" part of empathic validation. However, the validation portion of these cases is equally important for defining what constitutes empathic validation. In addition to demonstrating shared understanding, empathic validations must also be affiliative; that is, they must be provided in service of agreeing with or supporting the patient's position. Consider Extract 2 below as a contrasting example that is *not* empathic validation:

Extract 2 (P102_73yoF_9:10)

```
1     DOC:    You can have a seat again. Let's make sure you don't need any
2             blood work.
3     PAT:    Oh kay.
4             (1.5)
5     DOC:    O:h no. It was only a couple months ago.
6             (1.8)
7     DOC:    So you're ↑good.
8     PAT:    .tch! y- 'ave you seen anyting about my sugar?
9             (0.4)
10    DOC:    .tch! let's see::hh.
11    PAT:    De:er is a bloodwork that I was gonna te:ll ya I saw it on de
12            television and I wro:te it down to te:ll you. .hh It's a blood
13            test that they take for your cervik to see if you have
14            canc[er.
15    DOC:        [Oh. You're wa:y too old to worry about that.
16    PAT:    Really?=
17    DOC:    =Yes.
18    PAT:    heh heh heh heh
19    DOC:    E:ven- even if you (.) were exposed now it's too late.
20    PAT:    Mmhm
21    DOC:    Yuh- it would never gro:w.
22    PAT:    Oh[: oh.]
23    DOC:      [It ta]kes many many year[s. Okay?]
24    PAT:                               [Oh ↑okay] alright I see I was gonna
25            tell ya y'know [cuz sometime] you see ti[ngs.]
26    DOC:                   [Ye:::ah     ]           [Y- n]o:
```

In line 15 of Extract 2, the doctor also mentions how the patient must be feeling – worried – and this does go beyond the information the patient has provided in lines 11-14. However, the comment in line 15 done in service of reassuring the patient and assuaging her concerns rather than validating her feelings. The doctor does not validate the patient's worry by agreeing with how she patient feels; rather, she communicates why the patient does not need to feel the way she does (i.e. worried about cervical cancer). Additionally, unlike other empathic behaviors that rely on patients' ability to communicate their concerns before a response can be provided (e.g. reassurance, as in line 15 of Extract 2), doctors can provide empathic validations regardless of whether or not the patient’s talk explicitly seeks it. Even though the patient in Extract 1 minimizes the significance of his previous falls, the empathic validation in lines 24-28 positions the doctor as understanding of the patient’s struggle.

Just as some empathic behaviors may not constitute validation, not all validations can be considered empathic. For example, consider Extract 3 below. In this example, the doctor is reviewing the patient’s previous blood work on the computer to determine whether or not they need to order additional testing before she leaves the clinic:

Extract 3 (P141_82yoF_40:55)

1 DOC: I'm just seeing what's (.) been do:ne and not do:ne. So: that
2 °looks fine. You’re pretty- your levels look good, cholesterol is
3 fi:ne, .tch! .hh u::m oka::y I don’t know if we really need to do
4 any (.) extra blood tests today.° .hhh Blood pressure looks fi:ne
5 you take a li::ttle something for::- for high blood pressur:e,
6 [(.) it looks like? Okay.
7 PAT: [Yeah ( )
8 DOC: tch! and the medication for: cholesterol (.) and then the- your-
9 you don’t really take a lot. (.) **It’s pretty good.**
10 PAT: ( ) I’m basically healthy, I mean I really am.

Here, the doctor provides multiple pieces of evidence that the patient is in relatively good health by pointing out that her previous bloodwork looks good (line 2) and that she does not take many medications (line 9), providing the upshot in line 9 that “it’s pretty good”. The patient’s response in line 10 then aligns with (and upgrades) this assessment, casting the doctor’s positive appraisal of her overall health as validating. However, the doctor’s validation in line 9 is not an *empathic* validation because its design does not demonstrate a shared understanding between doctor and patient. Rather, in line 9 the doctor delivers her assessment of the patient’s health as one that is based on her professional evaluation of medical information – even providing online commentary in line 1 while she embodies this action by physically reviewing the patient’s past results on the computer. As this example shows, general validations can also be provided whether or not a patient has solicited it, but in order to be considered an *empathic validation,* the doctor's talk must go beyond just supporting the patient's position to address some shared understanding about the patient's feelings or experiences.

In addition to demonstrating shared understanding and affiliating with the patient's position, a third aspect of what defines empathic validation involves the design of this practice. Previous research about clinical empathy proposes that the patient's response is a key part of the interaction, and that it is only through studying patients' responses that conclusions can be drawn about the accuracy and appropriateness of empathy (Coulehan et al. 2001; Frankel 2009). For example, Coulehan et al (2001) propose that a patient's acceptance is key to successful expressions of empathy; thus, empathy can be accepted by patients if it is done correctly, but if not, it can also be rejected. This suggests that even when empathy is given in an appropriate moment, the format of the empathy is significant. For example, consider Extract 4 below, which includes two instances of empathy – one that the patient accepts, and one that she rejects. This patient has recently been diagnosed with early stage Alzheimer's, and now has full-time live-in help. The doctor asks her about her living situation during the visit:

Extract 4 (P114_90yoF_5:10)

```
DOC:      .hh Now_ (0.5) tell me about your living are you living by
          ↑yourself [still?
PAT:                [No. No no I have somebody.
DOC:      Oh goo:d.
          (3.2)
DOC: ->   That takes away some of your privacy doesn't it.=
PAT:      =It s(h)ure does(h). It's the pits
DOC:      Who made you do that.
PAT:      (um) W'l >who do you think.<
DOC:      [hnn HAH HAH HAH HAH hah hah] heh [heh heh
PAT:      [heh heh heh heh heh heh heh]     [Who do you think. My
          children.
DOC:      (0.8) Is it the same perso:n or do they rotate?
PAT:      Well one (.) comes fuh- five days a week and the other one (.)
          comes the weekend.
```

16 DOC: Okay.
17 (4.0)
18 DOC: -> **.tch! I'm sorry. ↑But at least you have a companion.**
19 PAT: (0.5) I don't need a companion. [Or- or] I should say I don't=
20 DOC: [(mmmm)]
21 PAT: =need those com[panions.
22 DOC: [heh heh heh heh heh heh .hhh have a seat for me.

In this example, the doctor correctly empathizes with the patient's problem – no longer being able to live independently, a reality that will not change given the patient's diagnosis – by making a statement about what the negative consequences are (losing privacy). The patient immediately agrees with the doctor in line 6, demonstrating that the geriatrician has interpreted the patient's feelings correctly even though the patient did not directly mention how she felt about her living arrangements. In contrast, the doctor seems to try to close this issue by offering a bright side to the patient's new living situation in line 18, but this formulation of the patient's experience is rejected wholeheartedly by the patient in line 19 (I don't need a companion). Previous research shows that bright sides can work to cast news as a mix of good and bad elements (Stivers and Timmermans 2017), but in situations where the patient has only indicated negative feelings (line 7), acknowledging only the negative consequences of the problem may be the most readily accepted format. Likewise, in other cases patients did not accept validations in other cases in which doctors provided a validation along with a bright side. When the validation matched the valence of the patient's feelings, however, patients tended to accept these expressions of empathy.

Finally, the provision of empathic validation does not depend on the presence of an existing relationship and can be provided to all patients. The ability to communicate empathically can vary among doctors, and medical professionals might attribute differences in empathic skill to individual variations. As Renée Fox explained, medical students are "inclined to feel that the so-called art-of-medicine skills are based not so much on trained experience as they are on personal qualities" (Fox 1957, p. 233). Further, expressing empathy effectively can hinge on one person's knowledge about the other, so it could be argued that doctors who are treating new patients are at a disadvantage and may not be able to express empathy as effectively. However, I find that empathy can be equally effective no matter how long the doctor and patient have known each other, and I argue that these skills can indeed be developed based on trained experience. For example, consider Extract 5 below, in which the patient is meeting the doctor for the first time:

Extract 5 (143_70yoM_0:00)

```
1   DOC:    Hi is this: (.) Mister Wexler?
2   PAT:    HI:: [yes hello::
3   DOC:         [Hi:: sorry I'm (0.5) late getting to you:, [how are you]=
4   PAT:                                                     [(         )]
5   DOC:    =toda:y?
6   PAT:    Good good [how are you
7   DOC:              [And thank you so much for filling this fo:rm ou:t,
8   PAT:    Oh yeah I (.) realized I think I left some thing(h)s (h)out
9           heh [heh unless-
10  DOC:        [↑Uh::: w'll it seemed- you seem very ↑detailed which is
11          goo:d,
12  PAT:    Uh huh, thanks=
13  DOC:    =Um: I was actually (.) ↑impressed it seems like you're pretty
14          independent and doin pretty well at ho::me,
15  PAT:    Ye:s. [But]
16  DOC:          [and] that your your heart's your trouble-
17          [(0.8) trouble problem hu:h] and the sleep.
18  PAT:    [Yes.   Right.     Right.  ]
19  PAT:    I'm mo:re taking care of Ri- Rita: cuz: [(0.5) her] sh- sh-=
20  DOC:                                            [ Mhm:    ]
21  PAT:    =she's you know diagnosed with early Alztime[r's. (.) Alzheimer's.
22  DOC:                                                [YES.
23  PAT:    B't (0.8) she doesn't believe it but(h) heh heh
24  DOC:    Well [it's har::d tu:h (0.8) sort of  ] (0.5) ih- it's ha::rd in=
25  PAT:         [.shh yeah it's it i:s, yeah. So.]
26  DOC:    =the beginnin:g with thuh: um: .tch! when you're first >diagnosed
27          with it< cause you still have a lot of insight and awareness? and
28          it's [(0.5) ] nobody wants to hear that [(.) diagnosis you know]=
29  PAT:         [Right.]                           [No:. She's (.) very   ]
30          [(0.5) indig(h)na]n(h)t
31  DOC:    [=it's it's very-]
32  DOC:    She's not here today is she?
33  PAT:    She's downstairs doing her INR…
```

Within one minute of meeting the patient, the geriatrician expresses an empathic validation by substantiating the challenges of his situation and elaborating on why it might be difficult for the patient's wife to believe she has Alzheimer's. Not only does this support the patient's assessment about his wife's condition (line 23) by providing evidence for this position, but it also validates his wife's struggle – a person who is not present and the doctor has never seen before. Thus, while expressing empathy in the form of validation can be informed by a doctor's knowledge of the patient individually, it can also be effective when drawn from a more general understanding of the patient's circumstances. These do not need to be mutually exclusive, however; in Extract 4, the geriatrician draws on both her general knowledge about the transition from living independently to requiring assistance at home as well as her knowledge about this particular patient (who wanted to remain living alone).

4.4.2. When do doctors provide empathic validation?

Doctors most often expressed empathic validation in instances where there was no course of action to recommend; it was expressed as a last resort either when there was no medical solution available to address the patient's problem (54% of cases), or when no medical treatment was necessary (32% of cases). In other words, empathic validation was provided when the doctor reached the limits of medical knowledge and had nothing to offer that could cure or resolve the problem. For example, return to Extract 1; here, the geriatrician expresses empathy for the part of the problem that he is unable to resolve – an increased risk of falling – but provides medical recommendations for the part of the problem that he *can* help with – improving strength and maintaining balance.

Falling is among the top concerns for older adults and the risk for having a fall increases with age (Rubenstein 2006). This patient explains that he does fall more often than he used to, and in line 23 he explains that it makes him feel like a fool. The emotions that accompany distress about potential falls and loss of function can't be "cured", and the geriatrician can't change the reality that this patient indefinitely faces a risk of falling – and the host of potential complications that accompany having a fall. However, the risk for falling due to weakness and poor balance can potentially be improved. Accordingly, the doctor fits his response to each part of the patient's problem; first he responds with an empathic statement in lines 24-28, and then offers a solution for the issues of getting weaker and poor balance that the patient first mentioned at lines 2-3. Similarly, Extracts 4 and 5 also reflect the tendency for doctors to provide empathic validation when no medical solution was available to resolve the patient's problem; in Extract 4 the doctor is unable to change the fact that the patient can no longer live independently, and in Extract 5 the doctor cannot resolve the challenge the patient is facing with his wife's Alzheimer's diagnosis.

In Extract 6, this tendency to express empathic validation when no medical treatment is available is demonstrated even more explicitly; here, the patient has been scheduled to receive a test that could explain why she has been experiencing pressure behind her eye. However, she has also been told that a clinical solution is unlikely even if they are able to identify the source of the problem, so she and the daughter are unsure whether to go through with the test:

Extract 6 (P147_90yoF_2:40)

```
1   DTR:      .hh But- [I-          I  >said ] I'd run it by you, I don't know=
2   PAT:               [.tch I don't need it] ((eye contact with doctor))
3   DTR:     =if she< really needs to [take ] the te:st.
4   DOC:                              [.tch!]
5   DOC:     Yea:h so an- an I kno:w sometimes certain things makes you- make
6            you an:xious, so how do you feel about the idea of (0.2) knowing
```

7 about something they can’t (.) fix_
8 PAT: Why should I know it if they can’t do anything about it [heh heh
9 DOC: [Mhm.
10 Yeah it sounds a li:tt[le
11 PAT: [(I’ll) just wo:rry about it.
12 DOC: RIGHT.
13 PAT: Yeah.
14 DOC: Yes. And I think you know we’ve had stuff in the past that you
15 and I have been worrying about .hh and I know it makes you
16 anxiou[s and then we know] what- (.) what it does to your blood=
17 PAT: [Yes it does.]
18 DOC: =**pressure [too.**
19 PAT: [Naturally
20 (.)
21 DTR: Ri:ght. Ok-=so- °then I think I’ll just might miss it.°

In this example, the doctor’s comments demonstrate shared understanding (lines 5-6 and 14-15) and support the patient and daughter’s position (voiced in lines 1-3) – specifically, the position that additional testing is unnecessary because her problem cannot be fixed. In the following section, I outline the function of empathic validations and discuss what is achieved interactionally by expressing them in such contexts.

4.4.3. What does empathic validation achieve?

Within this context, doctors provided empathic validation for three main reasons: 1) to normalize changes in the patient’s health, 2) to acknowledge the difficulty of the patient’s individual situation, and 3) to recognize the patient’s actions or choices. First, an important part of the work that empathic validation accomplishes in this context is the *normalization of changes in patients’ health*. Common experiences for older patients – like the constant risk of having a serious fall and breaking bones (Extract 1) – are traumatic regardless of age, but are “normal” for older adults in the sense that they are more common and expected among these patients. Validations work to normalize both the occurrence of such experiences as well as normalize the feelings associated with them.

For example, in Extract 1 the geriatrician normalizes both the occurrence of falls for people the patient’s age (saying that it’s not something “we” do when “we’re” younger but does happen when “we’re” older) themselves after the patient has just reported having two, as well as the worry about falls. This works to alleviate the patient’s feelings of “feeling like a fool” for having a fall since the validation casts falls as a common event and concern for many people, not just the patient alone. Normalizing empathic validations commonly deployed general references such as “we” to convey that such experiences were shared and normal, in turn implying that the patient should NOT feel ashamed or guilty for having had this experience.

Extract 5 highlights another example of the normalization function of empathic validations. In this example, the geriatrician again uses general references of “you” (lines 26-27) and “nobody” (line 28), thus underscoring the shared and common nature of the patient’s (and his wife’s) experience with others. This casts their experience as “normal” in the sense that it is understandable to many people and that other people experience the same thing. In other cases, geriatricians accomplished normalization in this manner by expressing validations with general references such as: people, anyone, all women, or references to people with the same medical condition (e.g. Crohn’s disease).

Interestingly, patients often responded negatively in cases where the doctor used empathic validation to normalize the patient’s experience *without* a general reference term. For example, consider Extract 7 below:

Extract 7 (P107_80yoF_6:40)

```
1   DOC:     One forty over ninedy eight h
2   PAT:     Mmm,
3            (0.2)
4   DOC:     .h That's much better_ (.)  [yea::h
5   PAT:                                 [A- an:d you kno:w at ho:me it was::
```

6 one (.) thirty over seventy so I mean that’s (0.2)
7 DOC: It's going up. ((Doctor raises exam chair patient is sitting in))
8 (1.2)
9 PAT: .tch I guess part of the ne:w omron blood (.) pressure (0.2)
10 wrist cuff [(.) to] be su:re I was: (.) you know an I'm very=
11 DOC: [O:kay,]
12 =(.) careful with it, an I .hhh so I just kind of think, uh:
13 it's:: it’s every time I go into any medical [office.
14 DOC: [White coat
15 hypertension.
16 (0.6)
17 PAT: It's all I can think (of) >even though I< feel like I'm relaxed,
18 hh heh heh g(h)uess (h)I'm no(h)t.
19 (0.4)
20 DOC: E:ven my blood pressure goes up when I see the doctor. So like
21 (.) if you- >if you’d check< my pressure no:w it’d be about a
22 hundred but if ↑I go see the doctor it's one thirty.
23 (0.4)
24 PAT: One thirty is good for me thou(h)gh hah hah.
25 DOC: I kno:w. I'm just- even my pressure goes up.
26 (23.0) ((Doctor rechecks patient blood pressure))
27 DOC: Sorry. ((blood pressure cuff slips))
28 (8.0)
29 DOC: °Mm kay.°
30 (13.0) ((Doctor finishes checking patient blood pressure))
31 DOC: Eh: it's about one forty over eighty eight.[(0.4)] ↑I:t's okay.
32 PAT: [.tch]
33 PAT: °It's not terrible. (2.0) ((clears throat)) And I think it's
34 really less: heh heh heh!
35 (1.2)
36 DOC: Well it's the average that matters, not the once in a while
37 readings.
38 (6.0) ((Doctor puts blood pressure cuff away))
39 DOC: You enjoying your summer?

This example highlights the role of general references in accomplishing normalization for empathic validations. Here, the patient explains that her blood pressure is always higher in the doctor’s office than it is when she is at home. The doctor tries to validate the patient’s increase in blood pressure by first naming the patient’s experience – white coat hypertension – to which the patient responds with silence (line 16) before sequentially deleting the doctor’s comment by resuming her postulating about why her blood pressure may have increased (lines 17-18). The doctor then provides an expanded version of her initial empathic validation by relating to the patient personally, saying that she also experiences increased blood pressure when she goes to the doctor (lines 20-22). However, the patient rejects the doctor's comparison between their individual experiences and does not agree with the doctor's validation of her assessment, leading the doctor to ultimately change the subject instead (line 39). Patients also rejected doctors' attempts to make individual comparisons in service of normalization (rather than using general references) in other instances. This finding aligns with previous research showing that while patients may appreciate a doctor's display of empathy with a second story, they also "orient to their own role as the only participant whose experience should be at issue in the consultation" (Ruusuvuori, 2005, pg 218).

In other cases, the patient may be facing a problem that not only has no solution that the doctor can offer, but also cannot be normalized. This highlights the second main purpose for empathic validation: to *acknowledge the difficulty of the patient's individual situation*. For example, consider Extract 8. The patient in this example had breast cancer but is in remission now. She tells the doctor earlier in the visit that she isn't eligible for reconstructive surgery, so she wanted to have a breast reduction surgery to even out her breasts. The problem is that her health insurance will not cover a breast surgery unless the patient has had a mastectomy, meaning that she could be responsible for a bill over $30,000 if she decided to go through with the reduction. During the problem presentation phase early in the visit, the patient provides this explanation as an account for failing to make a decision about whether to move forward with a statin they discussed during the previous visit. The doctor reacts empathically during the patient's telling with a response cry (oh my goodness!), but doesn't comment further until the end of the visit, below:

Extract 8 (P142_77yoF_16:50)

1 DOC: .hh >Alright well< keep up the good wo::rk, keep up the exercise,
2 I'm very proud of you:, an' **I'm sorry to hear about the breast**
3 **re[duction] problem that's [very frustrating.**
4 PAT: [Yeah.] [Yeah because that- it i:s because my
5 grandparents (?) [.h and] s- so what >I'm gonna- I've got to-<=
6 DOC: [Yea:h.]
7 PAT: =(0.5) oh when I did see Sarah by the way. .h I'm not going on
8 any of thee um: .h st- (.) [th' arimidex? they were] talking=
9 DOC: [( ) yeah. Yeah. right.]
10 PAT: =about fer ten years? She's gonna wait and see how the studies
11 are some have to go back for a year.
12 DOC: Okay. .hh ↑**I just can't believe Medicare won't pre-approve these**
13 **things. Cuz they pre-approve me:dicines and stuff.=**
14 PAT: =Yeah they don't- they- (0.2) they won't pre-approve
15 DOC: A surgery.
16 PAT: e- eh- uh a breas:t surgery if you had a (0.2) lumpectomy and not
17 a mastectomy.
18 (0.8)
19 DOC: .hh And they don't cover:: like breast reductions in general?
20 PAT: No [cuz ( )
21 DOC: [Cuz breast reductions are often: covered because of(h) (.)
22 u:m (.) health purposes for like the stress on the ba:ck.
23 (0.2)
24 DOC: **From so:me insurances. °An' you don't have it. That's frustrating.**
25 **[I::'m sorry.°**
26 PAT: [Ye:ah it was frustrating. So anyway.

Prior research suggests that for instances of troubles-telling involving uncommon experiences, the experience is often treated as being "owned" by the experiencer (Kuroshima and Iwata 2016). Likewise, in this example the doctor's validation addresses the patient's individual situation rather than using a general reference for all older people because her situation is uncommon and thus cannot be normalized. Empathic validations employed for this purpose aligned with the patient's experience by either providing an upshot of the situation, providing additional justification for the patient's experience, or both. In Extract 8, for example, the geriatrician summarizes the patient's situation by saying that it's very frustrating (line 3), to which the patient responds by agreeing and then explaining what her next steps will be (waiting and reconsidering a new medication in a year). The geriatrician then expands on the frustration of the patient's situation further in lines 12-13. Unlike the normalizing cases, here the geriatrician does not use general references to describe the patient’s situation; rather, she highlights the unique struggle for this individual patient in lines 24-25 by drawing attention to the root of the issue: that this patient doesn’t have an insurance plan that will cover reconstructive surgery.

While the first two uses of empathic validation primarily involved cases in which the doctor had no medical solution to offer for the patient’s problem, the third application of empathic validation often involved those instances in which the patient’s problem did not necessarily require additional medical treatment. In these instances, doctors provided empathic validation as a way to *recognize the patient’s actions or choices* about their health or their life more generally. In these cases, doctors provided empathic validation to show an appreciation for patients’ efforts, opinions, or decisions. This form of validation allowed doctors to convey their appreciation for the patient’s autonomy, thus demonstrating their understanding of the patient’s role in the management of their health. For example, consider the following discussion about a patient’s weight loss in Extract 9:

Extract 9 (P154_68yoM_2:10)

```
1   DOC:    Yeah you've been trending do:wn. So this is- these are your
2           wei:ghts [u::m  ] going back to twenty fifteen, so almost .hh=
3   PAT:             [Uh huh]
4   DOC:    =you know two and a half yea:rs now of- of- weights, .h a:nd
5           it's kind of a nice slow decline, [.hh] u:m an I think that's=
6   PAT:                                      [Mhm]
7   DOC:    =what you've been working on so that’s congratulations.
8   PAT:    Well tha:nk you.
9   DOC:    Yeah. That shows good progress, and you’re- you know you keep
10          heading in the right direction. So that's .hhh great for blood
11          pressure=the heart likes it, it's great to avoid diabetes, (.)
12          °so:° it's just- (0.2) difficult for a lot of my patients to
13          do.
14  PAT:    .tch Yeah ice crea::m and thee uh: you know: I- I know Pat
15          told me before [.h ] I signed up with you: about the pre=
16  DOC:                   [Mhm]
```

17 PAT: =diabetes [(.)] I said to myself well (0.4) why- is- is the=
18 DOC: [Mhm]
19 PAT: =ice cream and the- [and the] cookies and the cake worth it?
20 DOC: [Right.]
21 DOC: ↑Right=
22 PAT: =It's not ↑worth it.
23 DOC: Yu:p. You're absolutely right (.) I wish all of my patients
24 u::h .hh felt the same way you did heh heh

The patient in this example has struggled with his weight for many years, and is still relatively young among geriatric patients (68 years old). Over the past few years he has been steadily working on losing weight and has done so successfully. The geriatrician provides multiple validations that recognize the patient's efforts in losing weight. First, he states that he knows this is what the patient has been working on, thus validating his effort in maintaining a steady weight loss over a long period of time (lines 7-9). He then expands on this initial validation further by providing additional reasons why the patient's efforts are beneficial, and casts the patient's efforts as more remarkable given that it is difficult for a lot of his other patients to do (lines 10-12). Unlike normalizing empathic validations that convey to the patient that they are not alone, these validations do the opposite; they single out the patient in order to express support their individual efforts and choices in maintaining their health. This is precisely what the doctor does in his third validation of the patient's weight loss in lines 23-24.

This category of validations was also applied in a number of instances where no additional medical treatment was necessary because the patient had not yet followed through with the previous recommendation. That is, doctors employed this third type of empathic validation to convey understanding for patients' medical misdeeds (Bergen and Stivers 2013), justifying potential reasons why patients may *not* have followed through with previously discussed health maintenance such as screening tests or taking medication as prescribed. In these instances, doctors used both general references and individual references to justify the patient's actions (or failure to act). This use of empathic validation minimized the patient's role in failing to achieve something by validating their actions as understandable either because they are common (e.g. "that system is very confusing…you're not the only one") or exceptional (e.g. "a lot's been going on with you in your personal life"). Thus, this application of empathic validation helps doctors show understanding for their patients' circumstances beyond clinically objective information about whether or not they have adhered to previous recommendations.

4.4.4. Gender differences in empathic validation

The previous sections discuss the tendency for empathic validation to be delivered in contexts where no clinical solution is available (or where no new recommendation is necessary) and explain that doing so can serve three main purposes: 1) to normalize changes in the patient's health, 2) to acknowledge the difficulty of the patient's individual situation, and 3) to recognize the patient's actions or choices. In this section, I build on the aforementioned explanations of *what* empathic validations are and *why* they are provided by addressing the question of *who* received empathic validations in this data set. In particular, I focus on the differences between empathic validations provided to men and women with respect to frequency, types of validations, and patients' responses to those validations.

Previous research suggests that attending medical visits accompanied by a companion can be beneficial for patients in terms of increased patient comfort, understanding, and improved quality and quantity of information discussed (Laidsaar-Powell et al. 2013). The findings in this study support this trend in some ways; overall, patients who attended visits with companions received empathic validations slightly more often than patients who saw the doctor alone. However, this trend reversed once the patient's sex was taken into account. As shown in Table 2, both men and women who attended visits with companions received fewer validations than those who attended alone, though the frequency of empathic validation decreased further for women compared to men.

Table 2
Frequency of empathic validations by visit characteristic

Characteristic	Number of validations	Total number of visits	Relative frequency (per visit)
Patient Sex			
Male	63	18	3.5
Female	66	33	2.0
Patient visits with companions present			
Patient alone	77	32	2.4
Companions present	52	19	2.7
Patient visits by sex and presence of companions			
Men alone	48	13	3.7
Men with companions	15	5	3.0
Women alone	37	14	2.6
Women with companions	29	19	1.5

The finding that women received less empathic validation than men is striking in light of existing literature suggesting that, in medical contexts, men and women create empathic opportunities (e.g. by naming emotions) in equal measure (Bylund and Makoul 2002; Hall and Roter 2002). Geriatricians reported that they see far more women than men in their clinic, and the patient sample in this data set reflect such a distribution. Yet, the women received less validation despite constituting a larger proportion of the clinic's patient population. In the present study, the presence of a woman seemed to be associated with a decrease in the number of validations doctors expressed. All companions who accompanied male patients were women, either the patient's daughter (40%) or wife (60%). Likewise, virtually all companions who accompanied female patients were women as well (75%) and in most cases the accompanying companions were the patient’s daughter (83%).

It is also worth noting some differences in the nature of validations provided to men compared to women. First, male patients tended to receive more validations that recognized their actions or choices *and* more validations that served to normalize changes in the patient’s health. Female patients, on the other hand, received far more validations that acknowledged the difficulty of the patient’s individual situation (and in turn, fewer of the other two types of validations). In other words, men more often received empathic validations focusing on internal factors (e.g. the patient’s choices or changes in health, as in Extracts 1, 9), whereas women more often received validations focused on the external challenges affecting patients’ health (e.g. validating the difficulty of events that have happened to them, as in Extracts 4, 8).

Second, although doctors’ empathic validations predominantly responded to negative patient concerns, men received more validations in response to positive circumstances compared to women. It is fitting that most validations responded to negative experiences given that patients primarily visit the doctor because they have an unresolved issue to address rather than because they have good news to report – but men also received more validations in response to negative concerns.

Finally, patients’ responses to empathic validation also highlighted some differences between validations provided to patients who were men compared to women. While men and women overwhelmingly responded positively to empathic validations, women responded negatively more often than did men. Thus, it is possible that women patients not only experienced a decrease in the quantity of empathic validation they received, but also in the quality; given that patient responses can indicate the relative appropriateness of the doctor’s attempt at providing empathic validation (e.g. by accepting it or not in the subsequent turn), more frequent negative responses among women patients suggests that the validations they received were less effective than those delivered to their male counterparts.

4.5. DISCUSSION

This study takes steps towards a more precise vocabulary and conceptualization of empathy in medical interactions by first defining and analyzing one particular expression of empathy – empathic validation – and then examining the context in which doctors provide it, the function it serves, and the distribution of its use among patients. Using conversation analysis to ground observations of empathic displays, this study shows that the most important defining features of validations are that they must demonstrate shared understanding of the patient's experience and must also support the patient's position regarding the experience at hand. Analysis of patients' responses to empathic validation highlighted the importance of disentangling different expressions of empathy and studying each one in its own right; as seen in Extracts 2 and 4, providing empathy in general is not always sufficient. The wrong expression of empathy at the wrong time can lead patients to reject doctors' attempts, while appropriately designed validations are most often accepted. Future work should continue to develop this typology of empathy to specify other expressions of empathy and the formats and contexts in which they should be delivered.

An additional advantage of this conceptualization of empathy in interaction is that focusing on individual expressions of empathy does not assume that patients are responsible for inviting it. While studies based on the "empathic opportunities" framework measure the success of a doctor's empathy by how well they respond to the empathic opportunities that patients create (Bylund and Makoul 2002), this study shows that doctors can express empathy quite effectively regardless of whether the patient has indicated that it would be appropriate to do so (e.g. by naming an emotion). Expressing concerns is already challenging for patients, and sensitive topics that could benefit from clinical empathy may be even more difficult for patients to raise. Thus, recommendations that rely on this expectation are limiting; patients should be able to receive empathy no matter how skilled they are at inviting it, and this study shows that doctors can indeed do just that with empathic validation.

What allows doctors to provide empathic validation without relying on a patient's explicit invitation is that this form of empathy draws on the doctor's understanding of the patient's circumstances – rather than their feelings per se – which often falls within familiar medical territory. For example, geriatricians are knowledgeable about many health-related changes that older patients face, and can thus provide empathic validations when patients report experiencing things like falls (Extract 1) or changes in living situation (Extract 4). Rather than designing training to improve recognition of and response to empathic opportunities, doctors in other specialties could employ empathic validations based on their existing knowledge of how patients experience clinical issues such as screening tests (Extract 6) or weight loss (Extract 9).

As Extract 5 demonstrates, empathic validations can also be used regardless of how well the doctor and patient know each other and thus have the potential to be used widely. While expressing empathy may be easier between those who have an existing relationship, it is still important for doctors to express empathy to new patients or to patients who visit the doctor infrequently. Patients from low socioeconomic backgrounds, for instance, may lack the resources to visit the doctor regularly and thus may not have the opportunity to develop an ongoing relationship that might facilitate empathy and understanding. Empathic validation, however, may be one tool that doctors can use to begin fostering rapport with these patients and make them feel understood. While these moments of connection may seem small compared to discussions about life-or-death treatments, they make a measurable difference to all parties involved; patients experience greater satisfaction and health outcomes, and physicians experience reduced burnout (Trzeciak et al. 2019).

Finally, these findings may provide unique insight into the care of older adults. Empathic validation in this study was commonly provided in contexts where the physician had no clinical solution to address the patient’s concern, and these circumstances are common among older patients who frequently experience chronic conditions that cannot be cured. Given that this patient group is growing and that all physicians who are not pediatricians will likely see patients who are older adults, learning more about interactional tools like empathic validation can be beneficial across many specialties and could potentially help reduce ageism in medicine by promoting shared understanding between doctors and patients.

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CHAPTER 5

CONCLUSIONS

5.1. THEORETICAL AND METHODOLOGICAL CONTRIBUTIONS

5.1.1. Assumptions underlying medical care

Longevity is often seen as the ultimate goal of health care, and consequently people are reaching old age in record numbers (United States Census Bureau 2017). But what happens when patients succeed in reaching this goal? There is no celebration or award awaiting those who make it to old age, or even a clear transition to usher patients from adulthood into old age. Rather, while successfully *reaching* old age may be viewed positively, actually *being* old still remains highly stigmatized and challenging to address.

This is particularly true in medicine, which has become the primary location for doing so (Estes and Binney 1989). A common response to coming face-to-face with aging in this setting is avoidance; doctors rarely choose aging-focused specialties like geriatrics (Fisher et al. 2014; Weiss and Fain 2009) and may sometimes limit the number of older patients they see (Adams et al. 2002). Or as Chapter 2 demonstrates, non-geriatrician internal medicine doctors highlight negative perceptions of aging when they addressed this topic, but they more often avoided talking about old age altogether. In recent years, pharmaceutical companies have even pushed the development of pills that aim “to put the brakes on aging itself” (Harrar and AARP 2019).

Nevertheless, the fact remains that life is finite and aging will, to varying degrees, affect everyone with each day that we continue living. Whether or not anti-aging scientists manage to turn “85 [into] the new 65” (Harrar and AARP 2019), most people will still have to face the “o” word one day – and as this dissertation suggests, that doesn't have to be a bad thing. By uncovering how people navigate the process of aging through interaction – including all of the uncertainties and stigma involved – this research shows that aging can be jointly managed by patients and physicians in a way that make these challenges easier to discuss.

In considering the ways in which aging is managed and confronted during primary care visits, this study considers another fundamental question about standard expectations of health and medicine; that is, what happens when the typical assumptions underlying medical care no longer apply? As Chapter 1 discussed, the first assumption is that the doctor has a clear recommendation to make for the patient's problem. Patients visit the doctor in search of solutions to their health concerns, but when it comes to older adults, providing an answer isn't always so simple or straightforward. Treating older patients often involves uncertainty about the role of aging in patients' health, and relatedly, the degree to which a given problem can be managed if it can't be cured. This makes it more challenging for doctors to provide clear-cut diagnoses and treatment recommendations, but not impossible to address.

As the findings in this dissertation show, there are several ways that aging-related uncertainty can be managed in interaction. Chapter 2 explains how both physicians and patients can introduce the topic of old age in a way that facilitates discussion and helps to personalize medical care. For example, findings showed that old age can be troublesome for physicians if introduced in the wrong context, such as when internal medicine physicians raised the topic of old age with respect to diagnosis. When used to explain what is *normal* rather than what is *wrong* with the patient, however, old age can normalize changes in the patient's health and make the associated aging-related concerns (e.g. whether to continue taking a medication or not) easier to talk about. Chapter 2 also showed how patients used the topic of old age to raise concerns that were of uncertain medical relevance, which is an important task for patients whose medical and nonmedical concerns can often overlap. One strategy that patients used was to relate their health experiences to aging, making statements such as “maybe it’s just old age”. Given that concerns about getting older fall squarely within the geriatrician’s domain, this strategy allowed patients to present problems that were of personal concern to them as clearly relevant to the medical context.

Chapter 4 highlighted another way that doctors addressed uncertainty during their interactions with older patients. In particular, this chapter revealed that when faced with a problem without a clear medical solution, physicians can provide a form of empathy called *empathic validation*. While non-specific treatment recommendations can lead to patient resistance in some settings (Stivers 2005a), findings in this chapter showed that older patients largely responded positively to empathic validation in this context.

The second assumption underlying medical care is that the patient will be able to carry out the doctor’s recommendation – or as many medication bottles dictate, “take as prescribed”. Older patients may not always be able to comply with recommendations (e.g. receiving a referral to physical therapy but being unable to get there), and the usual tendency to avoid aging in conversation may reduce opportunities for physicians to appropriately accommodate these constraints when recommending treatment options. However, Chapter 2 demonstrates that talking about old age can help physicians recalibrate patients’ expectations and normalize changes in their health or circumstances, while also helping patients to express their preferences around particular courses of action. Likewise, Chapter 4 explains how empathic validations can also normalize aging-related changes in patients’ health and alleviate potential shame or embarrassment for failing to adhere to previously agreed upon recommendations – actions that might otherwise be considered medical misdeeds (Bergen and Stivers 2013). On the other hand, Chapter 3 shows that older patients can preface their questions with *agency framing* to demonstrate that they *are* capable of managing their health independently.

5.1.2. Ageism in medical communication

Stigma is enacted through social interaction, and language in particular plays a profound role in the way that stigmas like ageism are created and perpetuated. In medical settings, physicians occupy an authority role and are thus in a privileged position to shape the meaning of stigmatized labels like “old” through their interactions with patients. This dissertation contributes to literature on ageism by uncovering some of the means that physicians use to talk about a stigmatized label – old – in a way that helps to reduce the stigma of aging rather than reinforce it. By leveraging interactional practices like those outlined in Chapters 2 and 4, for example, physicians can help reframe conventionally ageist patterns of communication into something more positive and productive.

In Chapter 2, findings indicated that talking about aging openly can establish a new frame of reference that does not stigmatize the patient for being old or for having conditions might not completely heal; rather, talking about old age allows the physician to focus on what *can* be done to maintain the stability of the patient’s health and to accept changes in expectations of care. Instead of avoiding old age or continuing to refer to older adults with inapposite labels such as “young man”, talking about aging allowed geriatricians to take the position that things may not be the same, and that is normal and okay. Chapter 4 supports these findings by specifying one particular expression of empathy that physicians can use to promote shared understanding and acceptance during interactions with older patients, especially in circumstances that are common for older patients and can contribute to ageism among medical professionals (e.g. concerns with uncertain solutions).

5.1.3. Agency among older adults

Popular models of patient-centered care are based on the idea that patients play an important role in making medical decisions and that each patient has a right to accept or deny the care they receive. However, older patients may struggle to meet the expectations of these models for a number of reasons. First, the cornerstone of such models is open communication (Bensing et al. 2000), but some studies report that older patients have difficulty expressing concerns (Bastiaens et al. 2007), may have disparate expectations of what patient-centered care entails (Belcher et al. 2006), and may ask fewer questions (Eggly et al. 2006). Second, older patients experience conditions that can limit their capacity to participate in decision-making the way it is imagined by patient-centered care models. For example, it is estimated that one in eight patients age 65 and older have some form of dementia, but a majority of these cases are left undiagnosed (Barnes et al. 2014). The possibility of unidentified cognitive impairment among older patients thus compels clinicians to consider the accuracy of their patients' judgment when engaging in medical decision-making.

This dissertation contributes to literature about agency by illuminating some of the ways that older patients work to dispel such concerns about their ability to participate in and manage their health. In particular, these findings demonstrate several practices that older patients employ to shape physician-patient interaction in an era of patient-centeredness – and ultimately, to influence the outcome of their own medical care. For example, older patients raised the topic of old age to justify their treatment preferences (Chapter 2), used agency framing to demonstrate responsibility for their health and underscore concerns of particular importance (Chapter 3), and defined what successful expressions of empathy look like through their responses to doctors' attempts at providing empathic validation (Chapter 4). Together, these findings emphasize the fact that older patients are proactive in communicating about their medical care and that they work to achieve idealized goals of patient-centered care (e.g. personalization of treatment recommendations), thus reframing ageist conceptions of interacting with older patients.

5.2. IMPLICATIONS FOR CLINICAL PRACTICE

The findings from this dissertation also make a practical contribution by offering suggestions for how communication with older patients should be understood and practiced in medicine. Research shows that seeing a geriatrician can improve older patients' health outcomes, but most older patients lack access to a geriatrician because their numbers are few (Hafner 2016; Mitka 2002). Although medical education has attempted to address this issue by expanding training in geriatric care for all physicians, negative attitudes about treating elderly patients may still limit the effectiveness of teaching efforts (Bagri and Tiberius 2010). This dissertation illuminates some helpful practices that could be taken up in many contexts to improve doctors' comfort with aging-related uncertainty and older patients' care. For example, Chapter 2 shows how doctors can talk to older patients about old age in a way that is productive and less stigmatizing (e.g. using age to recalibrate patient expectations of care). With time and further research, knowledge about these practices can be expanded to mitigate ageism through training and education of the medical workforce.

Chapter 3 highlights additional practical insights, suggesting that physicians should take notice of concerns that patients raise with agency framing. The structure of medical visits limits patients' opportunities to ask questions, and when they do ask questions patients can always opt to do so without using agency framing. The choice to preface a question with agency framing, however, underscores a patient’s perception of particular concerns as especially important. For example, in many cases agency framing signaled a patient’s continuing concern over a topic that had already been discussed in previous visits. Thus, doctors should thus consider responding thoughtfully to questions that are designed with agency framing, and perhaps expect to revisit these issues again in the future.

Finally, this dissertation can inform future experimental studies that seek to develop specific communications-based interventions for clinicians. For example, geriatric training programs aimed at educating the larger medical workforce in caring for older adults could compare a control group to an intervention group in which the physician was trained to raise the topic of old age in the particular contexts outlined in Chapter 2. Previous conversation analytic work has been applied this way in the United States (Heritage et al. 2007) and the United Kingdom (Barnes et al. 2019), even informing online communications training programs that have a more extensive reach than in-person methods (Parry et al. 2013). This dissertation provides a framework for developing evidence-based communications interventions that can address the “art” of medicine and help medical professionals improve health care delivery for vulnerable or complex patients at low cost.

5.3. LIMITATIONS

The sample in this study introduces some limitations regarding the degree to which these findings apply more broadly. First, the data were collected from a single, large academic institution in an urban area of the western United States. While this setting was beneficial in terms of recruiting multiple geriatricians – a rather scarce specialty across the country – the geographic location of this clinic does not capture the experiences of those in suburban or rural areas where access to and delivery of health care may differ. Additionally, the clinic in this study was ranked among the top centers for geriatric work and training. As a leader in the field of geriatrics, it is possible that the way physicians in this clinic practice medicine may inform medical practice elsewhere. However, it is also likely that the constraints that geriatricians face in smaller clinics with fewer resources and training may lead to very different interactions.

Second, the patient sample was not diverse. The clinic was located in a wealthy area of the city, which resulted in a patient sample that was largely white, upper-middle or upper class, and well-educated. It is possible that this sample may reflect the population of patients who visit geriatricians given that people from marginalized groups do not tend to live as long and that access to geriatricians is limited. However, this sample does not reflect the experiences of older patients from more diverse backgrounds.

Finally, these data are come from a cross-section of primary care visits and do not include longitudinal information about the patients in this study. Additionally, this study does not include patient follow-up interviews regarding the practices described in this dissertation.

5.4. FUTURE DIRECTIONS

This dissertation demonstrates some of the ways that medical interactions with older adults may not reflect physician-patient interaction scholarship that is based on younger populations; decisions about treatment and goals of care are often different for patients facing aging-related concerns, and as a result, so are their health care experiences. Research focused on older adults will only become more relevant as this patient population continues to grow; future work can apply the approach taken in this dissertation to other settings in order to extend our knowledge about how to best accommodate these patients.

In particular, future work should combine additional methods with those used in this study to capture a more complete picture of medical interaction, its construction, and its implications. For example, implementing methods such as video-elicitation interviews would provide further insight regarding the social meaning and practical outcomes of interactional practices like those described here. Additionally, longitudinal work would allow future scholarship to address the longer-term impact of interaction on physician-patient relationships – a critical component of patient-centered care.

Taken together, the findings in this dissertation reflect a unique approach to research on physician-patient interaction by focusing specifically on practices that can make interactions in medical settings more positive. Sociologists have exposed countless ways that disparities within categories such as race, gender and socioeconomic status occur in medicine and the impact these inequities can have. While the findings described here would not be possible without building on such scholarship, I believe that future work – across various situations, locations and groups – should take up this study's perspective and continue uncovering not just where disparities and challenges exist, but also how they can be made better.

5.5. REFERENCES

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APPENDIX I

CONVERSATION ANALYTIC TRANSCRIPTION CONVENTIONS

1. Temporal and Sequential Relationships

	A. Overlapping or simultaneous talk is indicated in a variety of ways.
[[	Separate left square brackets, one above the other on two successive lines with utterances by different speakers, indicates a point of overlap onset, whether at the start of an utterance or later.
]]	Separate right square brackets, one above the other on two successive lines with utterances by different speakers indicates a point at which two overlapping utterances both end, where one ends while the other continues, or simultaneous moments in overlaps which continue.
=	B. Equal signs ordinarily come in pairs – one at the end of a line and another at the start of the next line or one shortly thereafter. The lines connected by two equal signs indicates that the second followed the first with no discernable silence between them, or was "latched" to it.
(0.5)	C. Numbers in parentheses indicate silence, represented in tenths of a second; what is given here in the left margin indicates 5/10 seconds of silence. Silences may be marked either within an utterance or between utterances.
(.)	D. ordinarily less than 2/10 of a second.
((pause))	E. In some older or less carefully prepared transcripts, untimed silences may be indicated by the word "pause" in double parentheses.
-	F. A hyphen after a word or part of a word indicates a cut-off or self-interruption, often done with a glottal or dental stop.
	G. Underlining is used to indicate some form of stress or emphasis, either by increased loudness or higher pitch. The more underlining, the greater the emphasis. Therefore, underlining sometimes is placed under the first letter or two of a word, rather than under the letters which are actually raised in pitch or volume. Especially loud talk may be indicated by upper case; again, the louder, the more letters in upper case. And in extreme cases, upper case may be underlined. ex: word, word, Word

°	H. The degree sign indicates that the talk following it was markedly quiet or soft. When there are two degree signs, the talk between them is markedly softer than the talk around it.
↑ ↓	I. The up and down arrows mark sharper rises or falls in pitch than would be indicated by combinations of colons and underlining, or may mark a whole shift, or resetting, of the pitch register at which the talk is being produced.
< > <	J. The combination of "more than" and "less than" symbols indicates that the talk between them is compressed or rushed. Used in the reverse order, they can indicate that a stretch of talk is markedly slowed or drawn out. The "less than" symbol by itself indicates that the immediately following talk is "jump-started," i.e., sounds like it starts with a rush.
hhh	K. Hearable aspiration is shown where it occurs in the talk by the letter "h" -- the more h's, the more aspiration. The aspiration may represent breathing, laughter, etc. If the aspiration is an inhalation, it is shown with a dot before it. .hhh

2. Aspects of Speech Delivery, Including Aspects of Intonation

. , !	A. The punctuation marks are not used grammatically, but to indicate intonation. The period indicates a falling, or final, intonation contour, not necessarily the end of a sentence. Similarly, a question mark indicates rising intonation, not necessarily a question, and a comma indicates “continuing” intonation, not necessarily a clause boundary. In some transcript fragments in your readings you may see a combined question mark and comma, which indicates a rise stronger than a comma but weaker than a question mark. Because this symbol cannot be produced by the computer, the inverted question mark (¿) is used for this purpose.
:	B. Colons are used to indicate the prolongation or stretching of the sound just preceding them. The more colons, the longer the stretching.

3. Other markings

(( ))	A. Double parentheses are used to mark transcriber's descriptions of events, rather than representations of them. Thus ((cough)), ((sniff)), ((telephone rings)), ((footsteps)), ((whispered)), ((pause)) and the like.
(word)	B. When all or part of an utterance is in parentheses, or the speaker identification is, this indicates uncertainty on the transcriber's part, but represents a likely possibility.
( )	C. Empty parentheses indicate that something is being said, but no hearing (or, in some cases, speaker identification) can be achieved.