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**Multiprofessional views on Older Patients Participation in Care Planning Meetings in a Hospital Context.**

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## **Multiprofessional views on Older Patients Participation in Care Planning Meetings in a Hospital Context.**

### **Abstract**

Care planning meetings (sometimes referred to as family meetings) for older patients involve group decision making between the multidisciplinary team, the older person and their family. However, service user participation is challenged by the inequity of knowledge and power between participants, together with organisational and resource pressures for timely discharge. The effective use and perhaps, potential misuse of communication strategies within care planning meetings is of ethical concern to all participants. Habermas's essential critique of participatory communication provides insight as to how older people's involvement can be either enabled or blocked by healthcare professionals depending on their use of communication strategies. (Habermas 1984).

Seven discipline specific mini-focus groups provided an opportunity for healthcare professionals to reflect on the participation of patients over 65 and their families in care planning meetings. Findings explore healthcare professional's understanding of older patients involvement based on key dimensions of communicative participation, namely, mutuality, inclusiveness, patient centeredness and clear outcomes (Walker et al 2001). Whilst the benefits of collaborative decision making were confirmed, legitimate concerns as to the

quality of participatory practices, limited attention to group work processes and the exclusion of older patients with cognitive impairment, were identified.

Keywords: *care planning meetings, aged, patient participation*

## **Introduction**

“...the actions of the agents involved are coordinated not through egocentric calculations of success but through acts of reaching understanding. In communicative action participants are not primarily orientated to their own successes; they pursue their individual goals under the conditions that they can harmonize their plans of action on the basis of common situation definitions” (Habermas 1984).

The above quote from Jürgen Habermas’ theory of communicative action is applicable to care planning meetings (CPM’s) as it encapsulates the pursuit of common understandings, armonisation of goals and action plans and negotiation of situations without the use of coercion and power, all of which ideally underpin the use of CPM’s in acute hospital contexts. A CPM involves the patient, a number of family members and healthcare professional’s (HCP’s) in purposeful discussions concerning the patient’s illness, treatment, and plans for their discharge or care outside the hospital (Hansen et al 1998). The multidisciplinary team (MDT) comprising of doctors, nurses, occupational and physiotherapists and social workers have a vital role in facilitating and enabling the active participation of older patients and to carefully consider the patient’s wishes (Hedberg et al 2008; 2007). HCP’s have different understandings of what constitutes a CPM. This is reflected within the literature by a number of different terms for this process; family meetings (Griffith et al 2004), family

conferences (Hansen et al 1998), discharge planning conferences (Efrainsson et al 2003) and more recently care planning meeting (Popejoy 2005; Hedberg et al 2008). The variety of terms which exist to describe this forum reflect the possible functions that this process can encompass including; information sharing, explaining medical interventions, , discharge planning, collaboration and decision making. The CPM process requires a culture of collaboration between all participants (Dersteine and Hargrove 2001), and for this reason it may be an extremely significant and symbolic event for participants, particularly the older patient.

Such a myriad of terms and differing objectives suggests that there is a need for clarification about the nature and purpose of this small group process. However, the published literature offers limited insight into the communicative and group processes used by members of the MDT to facilitate patient participation (Froenck 2005) and to achieve the intended outcomes. Although this forum is intended to encourage the active participation and empowerment of older people and their families in decision making, significant doubts exist as to whether CPM's effectively carry out this function (Efrainsson 2004). Given the limited research as to the nature of participatory processes in CPM's (Griffiths 2004: Opie 2002) the purpose of this study is to explore the specific issues for older patients and their families in a clinical context through the perceptions and experiences of the HCP's. This study is part of a wider research project, 'Care

and Connect' which was carried out in a major teaching hospital in Dublin, Ireland. Its brief was to carry out exploratory research to examine the area of CPM's in clinical practice. A three stage action-research cycle was used which included participant observations of CPM's, focus groups with HCP's and semi-structured interviews with patient and family members. This article will present the findings from the focus group data.

### **Participation in Care Planning Meetings**

The promotion of patient participation has stemmed from the belief that patients have a right, and a responsibility, to be involved in their health care and decision-making (World Health Organization 1978; Audit Commission 1993). Hedberg et al (2008:2007) argue that HCP's have a significant role to play in enabling active participation of patients. A helpful background or broader canvas on trajectories of care is provided by Allen et al 2004 but it would appear from the literature to date that there is a lack of evidence based knowledge which focuses specifically on the CPM process and how to promote or impede participation in such conferences (Asplund et al 2000).

As previously mentioned, the strength and limitations of CPM's in achieving meaningful participation for older patients can be further understood from a

communication action perspective. The CPM is another form of ‘medical encounter’ (Mishler 1984) although in the case of CPM’s, the interaction is a more complex series of processes and has a diverse range of key participants, compared to the relatively simple doctor-patient encounter. Patients and family members are involved jointly in this communicative process and are encouraged to express their individual experiences of illness, disability, ageing and priorities for future care. By virtue of the subjective nature of such experiences, communication needs to be grounded and contextualised, reflecting a type of rationality that Habermas refers to as the *lifeworld* (Habermas 1984). Yet for HCP’s, the motivation for convening a CPM is more technical, reflecting organisational priorities and as a consequence, the communication style tends to be procedural in nature and dominates the culture within medical settings. This form of communication reflects a type of rationality Habermas refers to as the ‘*system world*’. Communication within CPM’s therefore involves a dialectical struggle between the subjective participation and needs of older patients and their families and the technical involvement and instrumental priorities of HCP’s (Barry et al 2001). This is not presuming that HCP’s are unaware or uncaring of the patient’s lifeworld, nor that they are disinclined to the use of more subjective communication, but that they themselves are powerless within the confines of the ‘systems world’ of CPM’s with naturally dominant communication processes which either ignore, block out or decontextualise the voice of the older patient and their family. Older patients are particularly

vulnerable to not having their voices heard, particularly when cognitive impairment or mental capacity are considered by HCP's as an issue. CPM's can represent at best an opportunity for HCP's to promote open and participatory communication between all participants through skilled facilitation or at worst, be a tokenistic procedure that reinforces the dominance of healthcare expertise and power through distorted communication which ultimately detracts from person-centered care planning.

As a complex version of a healthcare encounter, CPM's involve three critical phases (Hansen et al. 1998). The pre-meeting phase prepares the patient and family and develops objectives for the meeting in relation to the overall goals for discharge. The actual CPM aims to achieve these goals through interactive communication, exchange of information and problem solving between the participants. The patient and family, in consultation with members of the healthcare team, are able to make the decisions required for treatment and plans for the patient's future care. The final stage involves the follow-up and the implementation and monitoring of the care plan. The desired outcome from this group process is that the patient, family and HCP's mutually understand, and are satisfied, with the amount of information exchanged, care planning, that decisions are made with clarity, and thus the patient feels a sense of control (Ever 1981).

Active participation is a critical process in open communication and collaborative decision making. Participation in discharge planning is defined as receiving sufficient information and involvement in discussions about medical treatment, of goals and needs, care services and follow-up (Almborg and Ulander 2008). Involvement in discharge planning is essential for older patients because of their need for continued care and support after discharge from hospital. Older people rightly demand improved communication with their healthcare providers, and ask to be informed and empowered to make decisions regarding their health care. Used effectively, CPM's are a powerful means to achieve these outcomes (Griffith et al 2004). The level of open communication and participation by the older person in CPM's can be operationalised and measured according to the following criteria: feeling that information is shared (mutuality): feeling included in decision making (inclusiveness): feeling that there is someone you can contact when you need to (clear outcomes): and a feeling that the service is responsive to your needs (person centeredness) (Walker et al. 2001). Older patients' participation in clinical decisions can be problematic however with many barriers, such as ageist and discriminatory attitudes, communication difficulties and cognitive impairment. The different agendas and perspectives of HCP's, the hospital and in particular, the agenda of family members can have a crucial impact on older patients' participation.

Ever (1981) suggests that CPM's are not always coordinated by mutual collaboration amongst HCP's and service users, but by means of established work routines which are broadly applied to categories of patients, and by the operation of the traditional hierarchy of social relations in health care (elements of the systems world). CPM's may therefore result in limited participation and dissatisfaction of service users, culminating in poor decisions and care planning (Ever 1981). Studies report dissatisfaction with the level of patient and family involvement and suggest that this is the result of hospital systems and processes and the inequitable relationship between HCP's and service users (Walker et al 2001). This can therefore negatively impact on the level of communication and stress encountered by the older person (Hansen et al. 1998). Hedberg et al (2007) raised concerns that HCP's tended to talk *about* rather than *to* the patient in meetings and concluded that family members were seen as more important speech partners than the patient. This is another example of how any exploration of the lifeworld can be ignored or blocked by communicative processes but may also point to the fact that HCP's are dependant on family members to facilitate discharge of the older patient home.

Information exchange and decision making is sometimes considered by HCP's as routine and not demanding a high level of skill (Hansen et al 1998) however, group work is an inherently complex process. Handsley and Stokes (2009) talk about the impact of role proformity within MDT's and how hospital systems

effect the quality of relationships between HCP's and patients. Meanwhile HCP's knowledge of group decision making processes for older people is neither well developed nor articulated compared to extensive research on the use family group conferencing in child welfare contexts (Connolly 2006).

Creating a context conducive to participation is dependent on a range of factors such as the facilitation styles of the group, (democratic, autocratic) the number of participants, communication processes and level of consensus and conflict. Organisational pressures such as discharge deadlines, limited resources and time pressures can make for quick, efficient discharge planning practices which can contribute to the patient feeling coerced into processes and plans that may not be sensitive to their needs(Clements, 1995).

### **Description of the study**

The aim of the study was to collect qualitative data on HCP's participation in, and facilitation of, CPM's involving older patients so as to inform best practice for use of CPM's in the hospital in which the project was conducted. The study was therefore grounded in the practitioner researcher's experiences and observations as a medical social worker about how CPM's were used by HCP's to include or exclude older patients and their families in the clinical decision making process.

An interpretive inductionist approach was utilised, where the researcher approaches a problem from the perspective of theoretical sensitivity to existing concepts, ideas and the theory. The researcher plays an active and deliberate role in organising and assigning meaning to the data as a way of constructing higher-order categories and theories (Kuczynski and Daly, 2002).

Mini-focus groups were held with HCP's participating in CPM's involving or pertaining to patients over the age of 65 years and under the care of a consultant geriatrician.

HCP's involved in CPM's over a three month period during 2008 were invited to participate in focus groups which were discipline-specific as it was believed that participants would be more open to discussion as opposed to mixed groups. Overall seven discipline specific groups were run for (i) consultants, (ii) physiotherapists, (iii) occupational therapists, (iv) nurses, (v) speech and language therapists, (vi) dieticians and (vii) social workers. Each focus group lasted between 30-70 minutes and involved between two to four participations with the exception one discipline specific group where only one member was available. A total of 20 participants were involved in focus groups. Open-ended questions were used to explore professional's views of older adult's participation across the various dimensions of the group process, pre planning and agenda setting, participatory processes, decision making, outcomes and follow up. Analysis of the information on the notes from the focus groups

followed an iterative data reduction method. Convergent themes were noted and developed and supportive quotations were identified (Crabtree and Miller 1999; Kvale 1997). The study was registered as a quality assurance activity and reviewed for ethical consideration under hospital governance. Attention was given to complying with ethical protocols, for example, ensuring confidentiality of data and anonymity. Given the exploratory nature of this study the findings cannot be generalised. However the examples and issues described in this account many help to illuminate similar problems experienced in other clinical settings.

## **HCP's Views**

Focus group results are summarised under 4 main participatory communication themes: mutuality, patient centeredness, inclusiveness and clear outcomes, and illustrated by direct quotes .

### ***Theme 1: Mutuality and information sharing***

HCP's considered 'best practice' in CPM's as those where the purpose and goals were shared and communicated clearly and openly from the outset.

*I think a good family meeting is one where there are clear goals and purpose' (MDT focus group participant)*

Poor practice in CPM's was characterised by limited or non-existent pre-meeting preparation which tended to block further communication opportunities: for example, situations where MDT members had not anticipated questions or issues,

*'...a bad meeting is where we (MDT) are poorly prepared and questions which the patient or family ask are not anticipated by us, this can be very problematic' (MDT focus group participant)*

The mutual sharing of the expectations of older patients and family members prior to the meeting was considered critical to establish opportunities for participation and communication of older patients and families more subjective thoughts and feelings.

*'...I think that expectations need to be broached with family members so that we know any concerns they have before the meeting' (MDT focus group participant).*

Pre-meeting preparation was considered not only important for the older patient and their family members, but also for the MDT. This was repeatedly highlighted by social workers and occupational therapists.

*'...I think we would definitely benefit from a pre-planning meeting, especially for those very complex cases'* (social work focus group participant).

The need for written patient information booklet detailing the CPM process was suggested as a means of explaining the purpose of the meeting and orientating older patients and families in preparation for the meeting.

*'...the development of an information leaflet, detailing what a family meeting is and what the process is should be put together...we could also include a list of things that patients and families can do to prepare themselves for the meeting'*(MDT focus group participant).

It was suggested by the HCP's that the presentation of pre-meeting information could prove particularly useful for those patients with a cognitive impairment and who may have difficulty retaining verbal information and instructions.

The lack of punctuality of clinical staff attending CPM's was seen as indicative of variable degrees of priority given to CPM's and ultimately patient and family participation in decision making. It was recognised that MDT members who

arrived late contributed to anxiety levels of all attendees and was viewed as disrespectful, further blocking and ignoring the voice and rights of older patients to participate.

*‘People arriving late definitely make the meeting more stressful for everyone and are disrespectful’* (MDT focus group participant).

Underpinning this lack of respect as to the involvement of older patients and family members was the imbalance of power and status between professional and the ‘lay’ participants. HCP’s were aware of how their treatment of patients and families could impact negatively on the partnership and patients and families could be left believing that the MDT’s time was more valuable than their time, further undermining their confidence and agency in the clinical process.

*‘Why should our time be seen as more important than theirs? Most of the family members have had to take time off work to be at the meeting so it sends out a very bad impression when we are late’* (MDT focus group participant).

Social workers in particular believed that it was imperative that a blocked, set time should be allocated to CPM’s, thus creating a defined and acknowledged space for patient and family involvement. This perhaps reflected the fact that

Social Workers largely held the responsibility for organising and co-ordinating meetings.

*'Blocked meeting times would be hugely beneficial-I spend huge amounts of time trying to get agreement on a meeting time and date that suits everyone...'* (Social Work focus group participant).

However clinical consultants were not as supportive of this suggestion as they felt that the unpredictability of their schedules meant that they would be unable to commit to this arrangement. All HCP's recognized the symbolic value and attributed importance to a sense of partnership and mutuality of respect within the context of CPM's. They recognised the need to create opportunities to privilege the subjective experiences of older patients and their families over the clinical and organisational priorities.

### ***Theme 2: Patient Centeredness***

The facilitation of CPM's and the group skills of participating HCP's were considered essential for fostering patient-centredness and participatory practices. The importance of using strategies to maximise participation were identified.

*'The facilitator needs to have a high skill level in order to elicit contributions from everyone and ensure that the meeting moves along'*  
(MDT focus group participant) .

HCP's felt that a democratic and less authoritarian communication and facilitation style helped create a culture of partnership and collaboration. That exploring the subjective experiences of patients and families required different communication skills and strategies. The excessive use of jargon tended to reinforce hierarchical relationships between clinicians and patients, whilst HCP's attempts to de-mystify terms was an example of a more inclusive, and person-centered approach.

*' A bad meeting can occur if the facilitator doesn't have adequate skills and uses too much jargon or is very authoritarian'* (MDT focus group participant)

*'...patient's needs should be met with understanding to decrease distress and friction'* (MDT focus group participant).

CPM's frequently involve a large number of participants including various professional representatives and family members. It was recognized that large numbers of attendees could be both intimidating and alienating for older patients as well family members. The clinical and technical priorities of HCP's tended to dominate communication, engendering a process more akin to a one

way process than a mutual encounter. HCP's identified this significant barrier to active patient participation.

*'Sometimes the patient might as well not be there because they don't speak at all during the meeting'* (MDT focus group participant).

HCP's felt that they had a responsibility to address tokenism and support older patients. Practical suggestions were made in relation to facilitating and promoting patient participation.

*'...We should give the patients a chance to speak at the beginning of the meeting and to set any goals they might have as very often those with a cognitive impairment tend to get spoken over...'*(MDT focus group participant)

*'We need to keep checking in with the patients during the meeting'* (MDT focus group participant).

In order to promote mutuality and understanding it was also proposed that an agenda should be agreed with the older patient and their nominated family members at the beginning of the meeting.

*'Patients should be the first to speak at meetings as this would empower them and they should also be given an opportunity to meet with the MDT without their family present'* (MDT focus group participant).

It was considered that this could improve participation levels and give the older patient a greater sense of control over the meeting process.

HCP's were cognisant of the fact that often family members were more active participants in the meeting process than the older patients and were better informed about their rights and what services are available. The frequent use of the third person to refer to the older patient by both clinicians and family members resulted in a process of 'talking over' them during the meeting and thus diminishing the opportunities for active participation by the older patient.

*'Sometimes we all just talk over the patients, especially those with memory problems so they can't get a word in edgewise' (MDT focus group participant).*

*'Even if the patient is present, are we really involving them a lot of the time...how much are we speaking to the patients directly? Talking in the 3<sup>rd</sup> person is a big problem, someone needs to take responsibility to ensure that the patient understands and is involved'(MDT focus group participant).*

As conflict and distress can often arise during meetings, it was recognised that the facilitator required high mediation skills to competently facilitate CPM's. Some of the MDT felt strongly that social workers should facilitate meetings.

*'I think the social workers are better at handling sensitive issues'* (MDT focus group participant) and,

*'If the medical team facilitate, it isn't as structured and there is too much focus on medical issues'* (MDT focus group participant).

It was also suggested that Social Workers, because of their training and understanding of older patients' subjective experiences could offer emotional and psychological support to patients and families and could help establish a good rapport between meeting participants. However, others felt that the profession of the facilitator wasn't of importance and that skill level should determine who assumed the facilitator role.

The potential of family members to speak for or represent the 'voice' of the older patient, especially in cases where the patient had a significant cognitive impairment, requires more advanced group facilitation skills and sensitivity. Several MDT focus group participants suggested that a training program would be extremely beneficial so that MDT members were better equipped to manage the dynamics within meetings.

*'I really feel that I would benefit from proper training on how to handle difficult families during meeting- this is an area I find very challenging'*(MDT focus group participant).

### **Theme 3: Inclusiveness**

HCP's debated whether all older patients should be included in the CPM. Some felt that it was important to negotiate involvement with the older patient prior to the meeting.

*'We should be asking the patients who they would like to attend their meeting....sometimes the patient doesn't want to be at their meeting and they shouldn't be harassed to attend'*(MDT focus group participant).

Others were concerned as to the implications of making attendance mandatory.

*'Is it not abusive to insist on someone attending if they are very confused or distressed?'*(MDT focus group participant).

It was the accepted practice that older patients with a cognitive impairment should routinely attend their CPM unless they did not wish to attend or, if it was likely to cause them distress: however, inconsistencies in practice did occur. The low participation levels of older patients with a significant cognitive impairment in CPM's were identified by the MDT as an issue of exclusionary practice that required further thought.

*‘...we need to have a consistent approach and guidelines about attendance and participation of cognitively impaired patients as different practices exist at the moment’ (MDT focus group participant)*

*‘There’s no point in bringing the patient along for lip service’ (MDT focus group participant).*

#### ***Theme 4: Clear Outcomes***

HCP’s felt the outcome of the meeting needed to be visible to all attendees if clear decisions are to be made.

*‘...patients and families need to be prepared for what is going to be said and that a decision **needs** to be made (MDT focus group participant)’*

Other MDT members felt that patients and families should not be pushed into making decisions before they are ready and that a time frame should be given for when decision-making needs to occur.

HCP’s recognised that particular challenges emerged when decision making was about medico-legal or technical matters. For example, ‘risky discharges’ or the decision to begin artificial feeding of a patient, were inherently ethically

challenging in nature and often the source of tension and conflict. The role and use of CPM's in relation to addressing such issues was as important but not clearly understood.

The ambiguous nature of CPM's in relation to a recognised protocol also reflected the lack of prioritisation and standardisation of meeting procedures. HCP's discussed the need for a minute-taker to be appointed and for formal records to be taken. The benefits of having a formal record of decisions made for the medical chart were also identified particularly in relation to important ethical decisions. However more formal procedures and protocols may make CPM's increasingly more technical and alienating for older people and their families and another means of coercive decision making. Some of the MDT members argued that,

*'...taking of minutes is a very good idea as people can have different understandings about what has been said or agreed'*(MDT focus group participant.)

Differences in opinions were again evident when it was proposed that a template for minutes should be developed and concerns were expressed,

*‘...who would take the minutes and type them up? Also, how would we get agreement from everyone about the content of the minutes, it would be very difficult to manage this in practice’* (MDT focus group participant).

However some focus group members felt that the current practice of each professional taking their own notes was sufficient.

*‘...I don’t see any evidence that current practices aren’t working, I feel that to have a written record of follow-up care would be more important’*(MDT focus group participant).

CPM’s are generally facilitated to aid decision-making yet given the demands of a busy hospital ward, it was not uncommon for meeting outcomes to be pre-determined so as to expedite hospital discharge. Some HCP’s considered CPM’s as a time to consult with patients and families on outcomes that had already been achieved/ decided.

*‘Meetings are a consultation process on decisions largely achieved’* (MDT focus group participant).

There were significant differences in opinion emerging between MDT members as to the stated purpose and desired outcome of CPM’s which were ultimately reflected in the way in which communication was addressed in such contexts.

Some believed that CPM's should be purely an information sharing forum where patients and families were then given time to make an informed decision.

*'I feel that meetings are often just an information sharing forum and if this is the case, could this not be done by each team member individually?'* (MDT focus group participant).

Others were of the opinion that this defeated the purpose of the CPM as the decision making should be a more open and participatory process which involved all participants in a joint decision making exercise.

*'...really decisions should be made during the meeting by everyone involved, what's the point in having a meeting if the decision has already been made...'* (MDT focus group participant).

## **Discussion**

The findings highlighted ways in which older peoples participation in CPM's were actively facilitated but as the same time ignored, blocked or denied. HCP's were cognisant that CPM's may not reflect participatory communication expectations given the lack of attention to basic group work processes, power differentials, open communication and organisational pressures. Mutuality between professional, patient and family participants, person centered and

inclusive practices, and clear outcomes help to empower older people in the discharge process and prevent CPM's from becoming tokenistic service user involvement (Arnstein, 1969).

One of the major barriers to older people's participation in CPM's appeared to be the lack of clarity as to the purpose of patient and family involvement in decision making and planning. Ambiguity existed as to whether CPM's were a forum for consultation, information sharing, and decision making or planning. Confusion over the rationale behind older people's participation tended to result in a more instrumental role dominating by default rather than by conscious intent. Working towards more a formalised acknowledgement of the role and status of CPM's would help to guide and regulate quality e.g. minute taking, meeting times, designating a meeting facilitator. Without more formalised recognition of CPM's, the actual participation of the older person, their unique experiences and expressed priorities are overwhelmed in a context which is clinically dominated. The dual themes of ambiguity of purpose and the discretionary nature of CPM practices were highlighted. Although not invariably considered a problem, given the complexity of care in later life, this level of discretion and ambiguity may allow for the manipulation of the participatory agenda and the continued domination of the clinical perspective at the exclusion of the wider needs of the older person. CPM's represent an opportunity for the expression and exploration of the lifeworld of both the

older patients and their families: however, this fragile space is vulnerable to manipulation or colonisation by the professionals' systems world.

Some HCP's were frustrated as to the use of a 'rubber stamping approach' to CPM's as opposed to more collaborative, transparent communication and participatory processes. They certainly displayed some understanding of the impact of the social imagination on their practice (Handsley and Stocks 2009). In some respects they felt that CPM's were dysfunctional, failing to achieve mutual communication and understanding with implications for less effective healthcare planning. They observed that the older person's subjective experience was not necessarily valued, nor privileged. A lack of transparency may thus indirectly and unconsciously promote ageist or paternalistic attitudes further diminishing the ability, and right, of older patients to fully participate in decisions. Yet despite this high level of insight, they did not feel that they were in a position to be actively promoting change and the voice of older people, perhaps because they had recognised the problematic nature of introducing subjective reflection to a technically driven system that ultimately strives to treat each patient in a manner which favours the systematic over the phenomenological. Handsley and Stocks (2009) identify a range of reasons for this, some of which go beyond the individual performance, falling instead within the institutional aspects, confines, and culture of the organisation as to

why professionals are inhibited in their commitment to more open communication with patients.

This study suggests that the physical involvement of older patients in CPM's does not necessarily guarantee genuine patient involvement or open communication. Similar to Hedberg et al's (2007) study, it was not uncommon for older patients to be talked *about*, in the third person, rather than talked *to* in the CPM. Family members were frequently attributed higher status by HCP's and exhibited higher levels of active participation than the older patient during CPM's. There is reference therefore to the possible 'tokenism' of patient participation within the CPM process (Brownlea 1987). The assumption that family members will automatically advocate for the needs of older patients is questionable given that relatives have their own agenda and priorities. HCP's thus have a crucial role to advocate on behalf of older patients during CPM's. however the engagement of an independent advocate for older patients in CPM's should also be utilised where available. This conflict of experiences and priorities between older patients and their family demands further study so that the perspectives of both can be equitably represented.

HCP's did not suggest that quality of care was compromised in any respect. It was more that open communication and active participation could add greater value to the decision-making process and the quality of care provided. There was no evidence to suggest that the limited involvement of patients actually

resulted in poorer outcomes for patients however, the older patients themselves may have felt differently.

Concerns were raised in relation to the use of manifestly exclusionary practices that beyond ignoring to actually denying the involvement of older people in CPM's. For example, older patients with significant cognitive impairment were frequently excluded from participating and appeared to have less opportunity for identifying either their needs or directly influencing their care plan at the meeting. Yet it is such groups of patients with complex care needs that participation and communication can have a critical impact on their care planning. Excluding such patients potentially excludes the key subjective issues that impact on their care in the community, although these aspects may be dealt with outside of the CPM. The notion of participation and choice needs to be redefined for older people with cognitive impairment and or 'borderline' capacity issues. Again this raises issues as to the rights and treatment of older people with conditions such as Alzheimer's disease and stroke within the hospital context.

Habermas(1987) argues that it is the interpersonal situation in which we converse that provides the necessary context for informed opinion and change. Power may lead to distorted communication, but by becoming aware of the ideologies that dominate in society, HCP's can themselves not only strive to empower older people, but also be empowered to transform their praxis. The

opportunity to exercise self-determination must be afforded to all patients and taken seriously which is very much the opposite of a paternalistic approach, in that the patient is given the opportunity to take responsibility for him/herself.

While there is merit in Habermas's theory of communicative action, a complicating factor of using this conceptual framework are components such as patient dimensions(cognitive impairment) and relational factors(competing and conflicting agendas) which much be acknowledged.

It is important to note though that the findings of this study also highlight examples of good intent and practice. CPM's are undoubtedly a vehicle to facilitate the discharge planning agenda of the hospital as an institution however, they also signify a move towards a more inclusive, patient centered approach and a move away from paternalistic professionally dominated decision-making. HCP's were committed to the continued use of the CPM process as an effective tool for inclusive decision making and as a consequence had insight as to the risks and pitfalls of service user involvement. There was recognition that person centeredness requires an understanding of, and attention to, group processes that promotes older peoples participation as well as outcomes (Walker et al. 2001). HCP's demonstrated a capacity for innovative strategies to promote participation however,such opportunities are dependent on the support and resources of the organisational context.

Empowerment has been conceptualised as a shifting or dynamic quality of power relations between two or more people such that the relationship tends more towards equity (Labonte 2004). It is hoped that this study has instigated a move in this direction through a tilting of the balance of power, the older person becomes central to the CPM process. It is important to acknowledge that power does not always have to have negative connotations and CPM's can be a mechanism whereby older people can reclaim power over their healthcare and care planning.

The issue of older patients' participation requires a multi-dimensional approach that is both micro and macro in nature and assessments of patients should be strengths-based and focus on retained skills and knowledge rather than deficit-focused. It is important for HCP's to address implicit hierarchal power structures and to realise that valuable input and contributions can be gained from older patients by attending to power issues. In this way, the various forms of knowledge are seen as complementary and HCP's can learn from patients and families and vice versa.

### **Conclusions and Implications for Practice**

This study demonstrated the importance of clarity of aims and outcomes, mutuality of relationship between participants, and the use of patient centred and inclusive practices to achieve truly participatory CPM's. Practical

suggestions to be considered include extensive pre-meeting consultation with older patients and their families, adoption of open and democratic meeting facilitation styles, documentation of outcomes and plans and post-meeting follow up.

Written information on the purpose and processes involved in CPM's would facilitate older patients and family member's participation. Enabling the participation of older patients with cognitive impairment appears to be an urgent priority.

There is a need to move away from the rhetoric of patient participation in CPM's to actually implementing it in the maximum way possible in clinical practice. HCP's must come to terms with the 'elephant in the room' and recognise the power they have in relation to patients' lives. The power imbalance between the clinicians, patients and family members must be made transparent and openly discussed at the multidisciplinary team level. Unless this issue begins to be addressed, the CPM process can never be truly participatory.

Participation therefore needs to be a function of not only organisational and administrative arrangements, but must also be carefully constructed at an interpersonal level if it is to occur in a meaningful way (Ashworth et al.1992).

In summary, CPM's work best when facilitated by skilled professionals trained in small group processes and with knowledge of the sociological imagination, power and patient autonomy who employ empowering strategies to address

these issues. Social workers are perhaps in a unique position to work with HCP's in clarifying the reality of the limits to choice and the involvement of the patient and family. They can provide expertise in the facilitation of such processes and support the patient and the family in their participation of problem solving, advocacy, and mediation.

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