

Global Qualitative Nursing Research

Admission Decision-Making in Hospital Emergency Departments: the Role of the Accompanying Person

Journal:	<i>Global Qualitative Nursing Research</i>
Manuscript ID	GQNR-19-0055.R2
Manuscript Type:	Single-Method Research Article
Keywords:	Caregivers, Caretaking, Emergency Care < Crisis, Crisis Management, families, decision making, Doctor-Patient, Nurse-Patient < Communication
Regions, Cultures, and Peoples:	Western Europe < Europe, Europeans
Methods:	Field Work < Research, Ethnography < Research Strategies, Case Study < Research

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Manuscripts

Admission Decision-Making in Hospital Emergency Departments: the Role of the Accompanying Person

Short running title: Caring decisions in the emergency department

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Abstract

In resource-stretched emergency departments, people accompanying patients play key roles in patients' care. This article presents analysis of the ways health professionals and accompanying persons talked about admission decisions and caring roles. The authors used ethnographic case study design involving participant observation and semi-structured interviews with 13 patients, 17 accompanying persons and 26 healthcare professionals in four National Health Service hospitals in south-west England. Focused analysis of interactional data revealed that professionals' standardization of the patient-carer relationship contrasted with accompanying persons' varied connections with patients. Accompanying persons could directly or obliquely express willingness, ambivalence and resistance to supporting patients' care. The drive to avoid admissions can lead health professionals to deploy conversational skills to enlist accompanying persons for discharge care without exploring the meanings of their particular relations with patients. Taking a relationship-centered approach could improve attention to accompanying persons as co-producers of healthcare and participants in decision-making.

Keywords

Carers; caregivers; emergency department; emergency room; decision-making; ethnography; qualitative research; United Kingdom.

Introduction

Hospital emergency departments (EDs) - also known as accident and emergency departments, emergency rooms or casualty departments - are the main entry point to acute care in many health systems. In the National Health Service (NHS) in England, they offer unscheduled access for patients who self-present or are referred from primary or secondary care. People accompanying patients in ED visits, such as partners, relatives and friends, can play key roles in giving health professionals background information and helping to make decisions about patient care. They may also be drawn upon as a “hidden workforce” performing tasks for patients that may otherwise be carried out by nurses (Fry, Chenoweth, MacGregor, & Arendts, 2015), particularly in contexts of limited staffing (Bridges, Flatley, & Meyer, 2010; Gordon, Sheppard, & Anaf, 2010). Relatives may also be involved in ensuring patient safety in hospital (Merner, Hill, & Taylor, 2019).

Relationships between patients and carers (or caregivers, a term more commonly used in the U.S.A.) are influenced by multiple factors including the patient's medical and health history and the dynamic nature of illness and family situations, which may mean that caring roles and responsibilities change over time (Swinkels et al., 2018). Despite this variation, in studies of hospital settings including EDs, analyses of carers', relatives' and patients' views and experiences are often combined. The use of dyadic categories such as 'patients and carers' or 'patients and relatives' can convey an assumption that all parties involved are equally focused on the fulfilment of patients' needs (Grimmer, Moss, Falco, & Kindness, 2006; Doos et al., 2014; Rainey, Ehrich, Mackintosh, & Sandall, 2013). Referring collectively to such parties as though they were united in their interests can create a sometimes unwarranted impression of established relationships and caring arrangements. Recent evidence suggests that, for adult patients in

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3 particular, caring relationships cannot be defined *a priori*. Rather, these are negotiated case by
4 case in processes that may involve carers, the patient and health professionals (Allen, 2000;
5 Aasbø, Solbrække, Kristvik, & Werner, 2016; Finch & Mason, 2003). United Kingdom (UK)
6 legislation and policy directives refer to carers' involvement in decision-making about patients'
7 care (Care Act, 2014). However, this guidance is inconsistently followed (Wingham et al., 2016).
8 Relatives and other caregivers value being included in decision-making (Fry et al., 2015;
9 Karnieli-Miller et al., 2012; Laidsaar-Powell et al., 2013; Nikki, Lepisto, & Paavilainen, 2012).
10 Professionals sometimes experience their interactions with patients' relatives as challenging, for
11 example when relatives intervene on behalf of patients, or when they disagree with medical
12 advice (Fry et al., 2015; Laidsaar-Powell et al., 2013; Pinkney et al., 2016).
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27 EDs in England are increasingly resource-strained and affected by crowding (Department
28 of Health, 2010; Higginson, 2012). During a 2013-14 mixed-methods organizational case study
29 of ED decision-making in four NHS hospitals across south-west England, the authors of this
30 article found that ED practitioners were temporally constrained by the NHS 4-hour target for
31 decision-making about patients' admission or discharge. They were also administratively driven
32 by contractual penalties that are charged to hospitals when this target is breached (Pinkney et al.,
33 2016; Department of Health, 2010; Weber, Mason, Carter, & Hew, 2011). Among findings from
34 the ethnographic component of our wider organizational study, we observed instances where
35 caring relationships were being negotiated in the reduced time-frame characteristic of the ED
36 setting (Pinkney et al., 2016).
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51 Our study sites used different models of emergency care, but all deployed multiple top-
52 down and ground-up initiatives to avoid unnecessary acute admissions. Some relatives and carers
53 expressed views about patients' admission or discharge that differed from those of health
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3 professionals. Patients and relatives sometimes disagreed among themselves about whether or
4 not the patient should be discharged home. Their considerations included not only how the
5 patient could be affected by staying longer in hospital, but also implications for the different
6 people who might be involved in practical arrangements for home care (Pinkney et al., 2016).
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13 Regarding the question of defining carers, it is now recognized that the use of this term
14 has been over-standardized. Traditionally, sociological analyses of carers' roles have
15 conceptualized these as instrumental to the maintenance of institutional systems, often influenced
16 by normative expectations about a duty of family support (Twigg & Atkin, 1994). More recently,
17 self-identification with carer roles and labels has been found to be "nuanced, shifting and
18 variable" (Hughes, Locock, & Ziebland, 2013). Not all people performing caring tasks consider
19 themselves to be carers (Orr, Barbour, & Elliott, 2013). Some people providing support in a non-
20 professional capacity (Beesley, 2006) represent their helping activities as an intrinsic part of
21 family relationships (Molyneaux, Butchard, Simpson, & Murray, 2011). Not all those named by
22 others as carers wish to act in this capacity (NHS England, 2014). A growing body of work
23 examines how people come to name themselves – or resist being labeled – as carers in particular
24 relationships or contexts (Aasbø et al., 2016; Molyneux et al., 2011; Chattoo & Ahmad, 2008;
25 Twigg & Atkin, 2009; Schumm et al., 2010; Aasbø, Rugkåsa, Solbrække, & Werner, 2017).
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44 *Focused Analysis of Cases involving Accompanying Persons*

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46 The findings of our wider study revealed that people accompanying patients in ED visits often
47 wished to be treated as partners in decision-making. However, they were rarely acknowledged in
48 this capacity, especially when staff considered that the patient's voice should come first. Those
49 accompanying patients lacked channels to formalize and support requests for their own concerns
50 either to avoid, or conversely argue for, an admission. For example, if they favored a hospital
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3 stay for an elderly patient, they could come into conflict with the patient's wishes and clinical
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5 advice (Pinkney et al, 2016).
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9 For the purposes of our focused analysis on this topic, we wished to avoid the automatic use of
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11 'carer' labels, as well as the value-laden connotations of other terms such as 'companions'
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13 (Laidsaar-Powell et al., 2013; Wolff & Rotter, 2008). We therefore adopted the neutral concept
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15 of 'accompanying persons' (APs) (Ekwall, Gerdtz, & Manias, 2009), making no *a priori*
16
17 judgment on whether or not people presenting with patients in ED did so as carers. We carried
18
19 out fresh, in-depth analysis of our sub-set of cases from the ethnographic study that involved
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21 APs. This may be understood as a mode of secondary analysis of self-collected qualitative data
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23 (Heaton, 2008), performed by the same team of primary researchers on cases we had reported on
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25 in lesser detail in our first publication from the study (Pinkney et al, 2016). The aim of this
26
27 analysis was to look more deeply into this group of cases involving APs, to answer two new
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29 research questions:
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35 1. How did APs present themselves and their relationships with patients to health professionals
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37 and researchers during ED visits?
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40 2. How did APs and ED practitioners negotiate issues relating to admission decisions and caring
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42 roles?
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45 46 *Research Design and Methods.* 47

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49 This focused analysis was carried out as part of a wider project that used a multiple case study
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51 design for a mixed-methods analysis of decision-making about admissions in four acute hospitals
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53 in south-west England (Pinkney et al, 2016). The study investigated how clinician expertise and
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55 models of care in the four hospitals contributed to decision-making regarding acute admissions.
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3 This involved investigating influences operating on the decision process and how the process
4 was experienced by patients and health professionals.
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8 The wider study generated ethnographic data from the four hospital EDs and associated
9 observation and decision-making units. The sites had been selected because of the structural
10 contrasts in the emergency medical admissions pathways which they were using at the start of
11 the study (Pinkney et al., 2016; Swancutt et al., 2017).
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18 The study recruited medical (non-surgical) participants for whom the clinical decision-
19 makers were not yet certain if admission or discharge was the best option. Participants were aged
20 18 or older. Patients and relatives were followed through their ED journey. The patients were not
21 clear candidates for any predefined care pathway, and they generally required some clinical
22 observation, investigations and discussion before an admission or discharge decision could be
23 made (Swancutt et al., 2017). Frequently social issues, such as the presence or absence of
24 support at home or in the community, had to be considered in decision-making. Four of the
25 authors [Rance, Brant, Holme and Swancutt] conducted participant observation and semi-
26 structured interviews on all sites between September 2013 and July 2014 during day, night and
27 weekend shifts, over periods of six to eight weeks in each site. We used purposive sampling to
28 seek maximum variation in the levels and roles of staff observed and interviewed, and in
29 patients' characteristics. In the latter part of data collection we did theoretical sampling of
30 patients to seek a balanced sample by gender, and an adequate range of ages and presenting
31 conditions.
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51 Although our ethnography was not designed as a conversation analysis study, our
52 methods were sensitive to language and context, and we were influenced by studies examining
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3 the social organization of talk (Atkinson, 1985) and the negotiation of institutional arrangements
4 in spoken interactions (Heritage, 1997). From such studies, we noted that taking a dyadic or
5 triadic approach to observing and interviewing (Laidsaar-Powell et al., 2013; Adams & Gardiner,
6 2005; Robson, Drew & Reuber, 2013) could highlight how participants shifted in their groupings
7 and patterns of convergence or divergence in naturally occurring interactions (“coalition
8 dynamics”) (Roscow, 1981; Biggs, Phillipson, & Kingston, 1995). In our focused analysis, we
9 looked closely at APs' self-positioning, their negotiations with professionals, and the influence of
10 their interventions on decisions taken to admit or discharge patients.
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22 *Participant observation and interviews.* In the wider study through which our data was
23 generated (Pinkney et al., 2016), written informed consent was given by all parties present in
24 settings where we made field notes or audio-recordings, and for all interviews. We recruited a
25 total of 282 health professionals, 65 patients and 30 'relatives and carers' (as we labeled them at
26 that time). Many of the encounters we observed could be qualified as ‘naturally occurring’, even
27 though - as is recognized in all forms of qualitative research - the researchers' presence was
28 inevitably influential.
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39 The ethnographic data set comprised detailed field notes (Emerson, Fretz, & Shaw, 1995)
40 of observations (n=107), transcripts of audio-recorded informal conversations and decision-
41 making encounters (n=242), and semi-structured interviews with patients, APs and health
42 professionals (n=96). Recording was done in full view of consented participants, and researchers
43 alerted anyone entering the room that recording was happening. Audio recordings were
44 transcribed verbatim.
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Analysis

As part of the wider study on ED decision-making, audio transcripts and field notes from the ethnographic data set were independently coded by three researchers [Rance, Brant and Holme] using NVivo10 (QSR International, Warrington, UK). We then merged our coding, agreed on a shared framework, and discussed our analysis to produce findings for the study report (Pinkney et al., 2016).

On the basis of subsequent discussions, together with a fourth researcher [Westlake], we carried out the focused analysis presented in this article to answer specific research questions on APs and their involvement in decision-making encounters. We here report on this new set of findings based on our re-coding of transcripts of interviews and observed encounters involving 13 patients, 17 APs and 26 health professionals (see Table 1 for features of the 13 cases). These 13 patient cases were selected with two inclusion criteria:

1. Presence of one or more APs
2. Availability of ethnographic data from observed interactions as well as recorded interviews (Karnieli-Miller et al., 2012; Kendall et al., 2009).

Our fresh coding of these 13 selected case studies produced new analytic categories concerning the place of APs in the ED environment and their disposition towards acting as carers. These led us to identify instances where APs discussed or negotiated tipping-points and transitions in their caring status and relationships.

Ethics

The NHS hospital study sites and identities of patients, APs and health professionals have been anonymized. NHS ethics and governance approval was granted (Integrated Research Application System reference number 98931, Research Ethics Committee reference number 12/SW/0173).). In our wider study, ethics approval was granted to carry out analyses relating to a broad range of issues regarding admission decisions, including the type of questions investigated in this paper.

Results

In the sections that follow, we describe features of patient cases involving APs. We then explore new analytic categories concerning the place of APs in the ED environment, including transitions in caring relationships. We examine variations and shifts in APs' expressions of willingness, ambivalence and resistance to being addressed as carers, or to taking on additional responsibilities in patients' forward care. Finally, we consider interactions we observed where APs were discursively 'talked into being' as carers.

In labeling the transcript excerpts cited, we differentiate between APs' declarations made in the presence of health professionals, and those made apart to researchers who thus had access to some rich 'back-stage' contextualization for the cases (Goffman, 1959; Scott, 1990).

Patient cases involving APs. Table 1 shows features of 13 patient cases. We gave pseudonyms to APs only, in order to highlight our analytic focus on them rather than on the patients or health professionals. Data on patients' mode of arrival in ED were not collected. Patients and APs were observed in different clinical settings, not detailed in the Table.

TABLE 1 TO BE INSERTED ABOUT HERE

Of the 13 ED visits involving APs, nine resulted in hospital admissions, and four patients were discharged. We do not claim that these patients' profiles or outcomes were representative of wider patterns. Rather, our analysis can serve to contextualize APs' presence, illustrate variability across cases, and examine the workings of APs' involvement in decision-making interactions and discussions about caring.

The place of APs in the ED environment. The ED was a liminal space between the context where a patient's health crisis had occurred and the acute ward, community or home destination following diagnosis. It was spatially bounded as a stopping-point for triage, treatment and observation. APs were commonly taken by ED practitioners to be a resource that could potentially support discharge strategies, especially for the avoidance of what they labeled "social admissions" (Pinkney et al., 2016) (often responding to a shortfall in home care or support services in the community).

All parties in the interactions we analyzed demonstrated awareness of ED pressures exacerbated by bed shortages and a build-up of cases competing for priority. Health professionals rationed care, and patients and APs were observed to self-ration their demands. APs sought to retain a place in the ED system through strategies such as demonstrating compliance with appropriate behavior, aware that the case of the patient they were accompanying was just one of many:

I had to ask the young nurse there, excuse me what is happening? And she said there is an awful lot of sick people here, so ... I don't expect to jump the queue, I don't ...

[Interview with Harriet (patient's wife) and the patient. Case 6.]

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3 In ED environments offering little privacy, with small spaces divided by curtained-off
4 cubicles, conversations about patients' conditions and people's personal lives were publicly
5 audible. Health professionals called on APs to give information on a patient's condition, offer
6 practical assistance while awaiting tests, decisions or discharge, provide transport, and back
7 up home care arrangements. Some APs were acknowledged to be good history-givers, but as a
8 norm backed by policy, health professionals insisted on hearing directly from patients unless
9 they had significant cognitive impairment. When an AP intervened, the health professional
10 generally kept their attention focused on the patient and continued to speak directly to them.
11 In such exchanges, an AP would not always receive a response from the professional.
12 However, in cases where patients were deemed less able to provide information, some APs
13 told researchers how, exceptionally, their input had been acknowledged:

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28 *Carol, patient's daughter, to researcher: I think what's been good is that the doctors have*
29 *actually listened to what we've said.*

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33 [Interview with Carol, Beatrice (patient's wife) and the patient. Case 2.]

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35 Some APs acknowledged strong ties with patients, but rather than defining themselves as
36 carers, they emphasized a particular quality or context of the relational bond:

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Ian, patient's son: We have an even closer bond than mother and son, because I had
renal failure, and mum gave me a kidney, so we've got, you know, an extra bond.

[Interview with Ian and patient. Case 7.]

Blood ties could be emulated in non-family relationships, as in the case of Olivia (Case
13), the AP who - without being a blood relative - enacted the most decisively engaged caring
role across our cases. She had known the 86-year-old patient for "40-odd years" and had lived
next door to her for 26 years. She proactively managed her friend and neighbor's care, often

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3 responded to health professionals and a researcher on her behalf, and identified with her to the
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5 point of representing dual candidacy for ED attendance:
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8 *Researcher (to patient): So what were you expecting to happen?*

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10 *Patient: I, well, I really didn't know.*

11
12 *Olivia (patient's friend and neighbor, to researcher): Well I was expecting to come in*
13
14 *thinking that they knew that we were coming. . . (...) I didn't visualize coming in here. . .*
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16 *And having all these tests. . .*

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19 *Researcher (to Olivia): So you know each other quite well then?*

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21 *Olivia: Very well, yeah. . .*

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24 *Patient: [laughter] Yeah, we've been through a lot. [Like] mother and daughter.*

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26 *Relationships in transition.* The encounters we observed took place during periods in which
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28 patients and APs occupied a space in the ED, engaged with health professionals, and sought to
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30 influence decision-making. Within the diversity of bonds between patients and APs, in some
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32 cases the ED visit signified a 'tipping point' into a new or unforeseen type of caring relationship.
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34 Some ED visits were triggered by the first sign of a condition that had not been detected
35
36 previously. The shock of an initial diagnosis or start to investigations could be compounded by
37
38 the AP's sense that the person on whom they had relied was now vulnerable and possibly
39
40 undergoing a transition in their longer-term health status.
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45 Some APs had not self-presented as carers, but the implications of needing to adjust to
46
47 such a role started to emerge even as they spoke:

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49 *Patient: I run my own small consultancy business. . . . If this is to be a recurring feature*
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51 *I'll have to wind that business up, I can't do it.*
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3 *Lucy, patient's wife: No. So, in some ways there's lots of stuff going on around this. . . .*
4 *you're in a situation . . . especially when we're coming into [name of town] and I'm*
5 *saying "Um, where do I go here? I don't know where . . ." . . . Driving his car. An*
6 *automatic and I don't drive an automatic.*
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12 [Interview with Lucy and the patient. Case 10.]
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14 In other cases, APs described deterioration in the patient's condition as gradual, but they
15 reflected with researchers on the abrupt transition from a relatively manageable health status to a
16 situation of increased dependency:
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21 *Ian, patient's son: . . . it's harder and harder for her to manage at home. . . (...) I think*
22 *this fall has. . . tipped it over, you know . . . (...) we can't be there all the time . . . we*
23 *need to get in more help, do we need Mum to have some respite care, what happens if*
24 *we're away...*
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30 [Interview with patient and Ian. Case 7.]
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3 *APs' disposition towards acting as carers: willingness, ambivalence and resistance.* Tangible
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5 resource constraints, and ED practitioners' institutionally mandated collaboration with admission
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7 avoidance, added weight to situations in which APs showed awareness of normative expectations
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9 that they would perform in a caring capacity. In response to the manifest or internalized pressure
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11 of such social and institutional norms, we observed how APs could shift between expressing
12
13 willingness to collaborate with health professionals in supporting different dimensions of
14
15 patients' care; ambivalence when being 'cast' by ED practitioners as a carer did not tally with
16
17 their own sense of a relationship with the patient; and resistance to taking on new caring
18
19 responsibilities, for example if an explicit commitment in this direction should be required to
20
21 enable discharge.
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27 *Willingness.* ED practitioners' admission or discharge decisions were sometimes
28
29 influenced by APs' proactive moves. This was illustrated in Case 8 where Judith (the patient's
30
31 wife) bypassed the couple's GP (General Practitioner or family doctor) to come straight to the
32
33 ED, brought the patient in equipped for an overnight stay, and argued successfully for his
34
35 admission. The presence of a supportive member of the patient's social network could facilitate a
36
37 discharge decision, as in Case 5 where Graham (the patient's new boyfriend) expressed
38
39 willingness to take on a home care role if this should be needed: '*I'm not going back to work*
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41 *until she's better, I'm not.*'
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46 In Case 10, Lucy (a former nurse) identified her husband's symptoms as typical of a
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48 stroke, informed health professionals of her observations, and concurred (as the patient also did)
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50 with their decision that he could be safely discharged with an outpatient clinic appointment
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52 booked for that afternoon.
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3 *Ambivalence.* As potential or prospective caring activities were discussed, some APs
4 expressed ambivalence about their readiness to adopt a new or augmented role. APs – some new
5 to ED scenarios and others who had experience negotiating the system – spoke more readily to
6 researchers ‘backstage’ than to health professionals about their personal situations and limits to
7 their willingness or capacity for acting as carers. Researcher presence was found to act as a
8 catalyst for reflexive comments by all groups of participants (Cant & Sharma, 1998). Some APs
9 used research interactions as an opportunity to talk through problems or reflect on their
10 relationships with patients, possibly finding it more comfortable to talk to the researcher who did
11 not have a stake in decision-making:
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24 *Ian, patient’s son, to researcher: It’s very, very difficult for me to get her to agree to*
25 *more help. . . . it’s quite a battle, because the roles are reversed now –*

26
27
28 *Researcher: Yeah.*

29
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31 *Ian: I’m telling her what to do – . . . She don’t like it.*

32
33 *Patient: Oh no, I don’t like it at all. [laughter]*

34
35
36 *(...)*

37
38 *Son: When we get older, the roles reverse.*

39
40 [Interview with patient and Ian. Case 7.]

41
42 The situation of being observed could also prompt ED practitioners to demonstrate how
43 they implemented the policy of involving patients and relatives in decision-making:
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46 *Consultant: (to patient) What do you think about that? Would you be happy with that?*

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49 *Patient: You’re the doctor, you tell me what to do [laughing].*
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3 *Consultant: No! I've got a lady here watching what decisions we make [referring to*
4 *researcher]. (To Daughters 1 and 2): What do you think? Does that sound okay?*

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7
8 *[laughing]*

9
10 [Recorded observation of interaction between consultant for care of the elderly, patient,
11 Doris (Daughter 1) and Elizabeth (Daughter 2). Case 3.]

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14
15 In this case, the 'best practice' behavior mindfully enacted by the consultant consisted of
16 formally involving not only the patient but also her daughters in shared decision-making.

17
18 However, the consultant's admission avoidance endeavor did not extend to the more subtle role
19 of exploring differences between the preferences of Elizabeth - who lived near her mother and
20 regularly supported her home care - and Doris, who lived further away and was less affected
21 from day to day by the consequences of her mother's deteriorating condition.

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28 *Resistance.* We analyzed a set of observed interactions where tension or conflict became
29 apparent in APs' negotiation of their roles. In such situations, while referring to their own needs,
30 some APs expressed emotions of shame or guilt linked to normative self-/expectations about
31 caring. There were cases where APs - despite giving signs of resistance - were 'talked into'
32 accepting caring responsibilities by ED practitioners' deployment of persuasive conversational
33 skills.

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42 In some cases, APs referred in positive terms to a pre-existing caring relationship with
43 the patient. In others, APs expressed difficulty in asserting their limits to caring, especially
44 when talking with practitioners. Some APs who were patients' relatives, and particularly
45 partners or spouses, expressed discomfort that seemed to be associated with internalized or
46 externally-applied pressure of normative expectations about caring roles (Swinkels et al.,
47 2018). In such situations, APs could use indirect cues to imply ambivalence or resistance.

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3 *Shame, guilt, irony and joking.* Given their apparent internalization of social and institutional
4 norms about duties of informally-provided care, APs in our study rarely expressed overt
5 resistance to taking on greater caring responsibilities. In the course of conversations that were
6 weighted towards the interests of patients and ED system arrangements, they interjected clues
7 about their personal constraints and limits, 'leaking' allusions to lifeworld situations (Heritage &
8 Maynard, 2006; Mishler, 1984):
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17 *Beatrice, patient's wife: I think that we have so much going on, with [daughter's]*
18 *mother-in-law and my mother . . .*

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21
22 [Interview with Beatrice, Carol (patient's daughter) and patient. Case 2.]
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27 *Kenneth, patient's partner: I can't do very much, I've not long been out of hospital*
28 *myself.*

29
30 [Interview with Kenneth and patient. Case 9.]

31 Normative expectations could make it difficult for APs to declare or hint at their limits to
32 caring when the patient they were accompanying was a family member. Some APs who had
33 argued for a relative's admission expressed emotions of shame (blame directed towards the self)
34 or guilt (about a statement or behavior that could be negatively judged) (Tangney, Stuewig, &
35 Mashek, 2007), which they immediately refuted in reflexive self-defense:
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45 *Carol, patient's daughter: . . . it makes me feel like that we're being awful, because*
46 *we're not.*

47
48 [Interview with Carol, patient, and patient's wife. Case 2.]

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51
52 *Ian, patient's son: Not that I want her to be in hospital, it sounds terrible, but I think*
53 *she's, at the moment, it's safer in hospital. . .*

54
55 [Interview with Ian. Case 7.]
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3 When the patient was a partner or spouse, voicing limits could be still more challenging
4 for APs because of the augmented expectation of a social obligation to care. In such cases APs
5 resorted to irony, joking, or oblique references to feelings of ambivalence, resignation or
6 dissatisfaction with caring responsibilities that in some cases had shaped their lives over long
7 periods:
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14 *Agnes, patient's wife: It's like there's a tap running because I've seen it all before . . . I*
15 *mean, well he's either going to come round or he's not [laughs]. Believe me, when*
16 *you've put up with this for 13 years nothing fazes you or me.*

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21 [Interview with Agnes and patient. Case 1.]

22
23 In some instances, APs alluded to their own wishes and needs when talking to
24 practitioners. However, on no occasion did this type of communication generate discussion about
25 support or respite for carers:
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31 *Kenneth, patient's partner, to occupational therapist (OT): Can you not keep her in for*
32 *a week?*

33
34
35 *OT: Pardon?*

36
37
38 *Kenneth: Can you not keep her in for a week?*

39
40 *OT: Not in this hospital but it depends – (...) if your partner couldn't manage at home*
41 *following this assessment we'd look at what options there are –*

42
43
44 *Kenneth: That was supposed to be a joke!*

45
46
47 *OT: Oh was it? [Laughs] I took it very seriously. (...) Well some people do – you know*
48 *want to stay in the hospital but it's not always the best place for their care so –*

49
50
51 *Kenneth: But it's going to be difficult for her to move about at home.*

52
53
54 [Recorded observation of interaction between OT, Kenneth and patient. Case 9.]

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3 Kenneth attempted to backtrack from his direct request that his partner be kept in hospital
4 by suggesting he had been joking, although his subsequent comment referred to her deteriorated
5 mobility. The OT practitioner appeared to capture the seriousness of his repeated request, but
6
7 reverted to a focus on the patient's interests without exploring Kenneth's personal concerns.
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11
12 *ED practitioners' persuasive conversational strategies: APs 'talked into being' as carers.*
13

14
15 Health professionals in our study had to assess cases without access to complete patient records,
16 through pulling together rapidly-gleaned understandings of patients' living arrangements and
17 support networks. When we explored the effects of time and resource pressures on ED decision-
18 making in the wider study, our initial interpretation was that health professionals supposed that
19 APs acted willingly as carers and that they were available to support patients' discharge if this
20 should be judged clinically viable. However, focused analysis of our interactional data indicated
21 that ED practitioners did conversational work, when needed, to persuade ambivalent or resistant
22 APs in that direction (Billig et al., 1988) and 'talk them into being' (Heritage, 1984) as carers.
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33 In some cases, health professionals' efforts to facilitate discharge were concordant with
34 the wishes of the patient and an AP. However, when there was overt or hinted-at discrepancy
35 between an AP favoring admission (and reduced home care responsibilities) and an ED
36 practitioner favoring discharge (with greater reliance on informal home care arrangements), the
37 decision-making balance was invariably tipped by the weight of institutional authority
38 represented by the practitioner. 'Talking carers into being' took the form of health professionals
39 listening to APs' arguments for admission (rather than assuming they would support discharge),
40 and immediately elaborating responses to counter these arguments. When APs introduced their
41 own arguments such as fears about risks for the patient, ED practitioners responded by
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3 dismissing the validity of one concern after another, proposing solutions that focused on
4
5 supporting patient mobility and safety.
6

7
8 This type of negotiation could be complicated by shifting AP-patient coalitions (Roscow,
9
10 1981), as shown in the example that follows. A 70-year-old patient, attending ED after a dizzy
11
12 spell and collapse, was accompanied at different times by two daughters and two sons (Case 3).
13
14 There was divergence among the siblings regarding the advisability of their mother's admission.
15
16 Doris (Daughter 1) stated: "there's no point keeping her in", a view echoed by the patient.
17
18 Elizabeth (Daughter 2), who lived closest to her mother, expressed concerns about risks of her
19
20 falling at home. Elizabeth's arguments were overcome by a consultant for care of the elderly
21
22 who eventually secured the family's collaboration with discharge.
23
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26
27 In another case, an 86-year-old female patient affected by dementia resisted the idea of
28
29 admission after a fall (Case 9, see Table 1). She and Kenneth, her 90-year old partner, were
30
31 sometimes referred to by health professionals as a married couple, although each alluded to their
32
33 "living in sin" relationship and basic independence. Kenneth, who had recently undergone a
34
35 hernia operation, argued against the patient's discharge home. Two ED practitioners enquired
36
37 about their domestic arrangements with practical intent, but neither of them explored Kenneth's
38
39 willingness or ability to provide increased home care:
40
41

42 *Junior doctor (to patient): Okay lovely and you've got your partner at home with you. Do*
43
44 *you have any carers?*

45
46
47 *Patient: We have a lady who comes in and does a bit of vacuuming*

48
49 *Junior doctor: Okay and you manage perfectly well between the two of you? Lovely.*

50
51 *(Case 9. Recorded observation of interaction between junior doctor, patient and*
52
53 *Kenneth.)*
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3 *Occupational therapist (OT, to Kenneth): Have you got any questions or anything at the*
4 *moment?*
5

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7
8 *Kenneth: Well yes I'm rather concerned about her mobility –*
9

10 *OT: Her mobility, okay. What type of accommodation are you in? Is it a bungalow?*
11

12 *Kenneth: It's a bungalow.*
13

14 *OT: A bungalow. Well that's good news. (...) I've got lots of mobility aids and things like*
15 *frames and I think probably – [to patient] you probably might need a frame to walk with*
16 *just while your fracture is healing, just because it can give you some extra support.*
17
18

19 *(Case 9. Recorded observation of interaction between OT, Kenneth and patient.)*
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24 The junior doctor made a move to talk informal home care into being - “Okay and you
25 manage perfectly well between the two of you? Lovely” – but the patient was eventually
26 admitted because of her fracture. The above cases illustrate a parrying movement between APs’
27 arguments about risk and health professionals’ assertions about safety. Issues underlying some
28 APs’ objections to discharge – their own autonomy, living situation, health, and type of
29 relationship with the patient – were invariably left unexplored.
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33 *Discussion* 34 35 36 37

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39 Many individuals who accompany patients in health service visits do not regard themselves as
40 carers (Molyneux et al., 2011; Hughes et al., 2013). Some consider the carer label to be
41 inappropriate for them, and others demonstrate difficulties coping in this role (Wingham et al.,
42 2016). APs' attempts to contribute to negotiations about caring may be "squeezed out" of
43 decision-making by busy clinical schedules, lack of patient consent (Al-Janabi, Nicholls, &
44 Oyeboode, 2016), and health professionals' focus on the patient's voice. A clinical criterion that
45 discharge is in the patient's best interest may challenge an AP's view to the contrary. Tensions
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3 can emerge among the positions of all the parties involved, for example, when 'social admissions'
4 are considered due to gaps in home care or community services (Pinkney et al., 2016).
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6

7
8 APs in our study gave clues to health professionals and researchers about situations that
9 influenced their willingness or ability to comply with normative expectations about caring roles.
10
11 APs' shifting modes of engagement resonated with evidence from a study on patients with
12 multiple sclerosis indicating that relatives and friends alternately “embraced, enforced, absorbed
13 or rejected” identities as carers (Hughes et al., 2013). Interspersed with discussions about patient
14 safety, tasks to be performed and domestic adjustments, we also noted pivotal moments in which
15 APs reflected on their relationships and prepared themselves for new roles.
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24 Physician communication can have a critical impact when a person is transitioning from
25 accompanying person to carer (Karnieli-Miller et al., 2012). ED practitioners may use persuasive
26 conversational strategies (Boyd & Heritage, 2006; Roy-Chowdhury, 2006), following an orderly
27 sequence and avoiding overt conflict (Sharrock, 1979), to talk APs into taking on extended
28 caring functions for system expediency. The drive for admission avoidance can school health
29 professionals out of exploring the particularities of patients' relationships with people
30 accompanying them. APs, as well as patients and professionals, require time – a scarce
31 commodity in EDs, globally (Chandler et al., 2015) - to communicate effectively and negotiate
32 transitions in caring arrangements.
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45 Health professionals and patients sometimes 'cast' people as carers (Grimmer, Moss, &
46 Falco, 2004), although APs in our study rarely referred to themselves in this way. However, ED
47 practitioners did not need to use the carer label to enlist APs' support for discharge. It was
48 sufficient, for purposes of supporting the resource-strained emergency system, to talk them into
49 willingness to take on new or additional caring tasks. Such conversational persuasion brought
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3 pressure to bear on APs, sometimes triggering a sense of shame or guilt. Negative feelings about
4 the self can provoke attempts to escape the shame-inducing situation, and the "hidden cost" of
5 defensiveness and interpersonal separation (Tangney et al., 2007) may be detrimental to caring
6 relationships.
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12 Carers are not systematically addressed as co-clients and co-producers of the emergency
13 system, and there is a need to detect "unacknowledged stress" and enable them to access
14 available support (Tangney et al., 2007; Wingham et al., 2016; Al-Janabi et al., 2016; Georgiadis
15 & Corrigan, 2017). "Carer-proofing" of decisions has been proposed to reduce strain on family
16 carers for patients with long-term conditions (Al-Janabi et al., 2016). The concept of a
17 "therapeutic alliance" has been used to explore relational factors including "intuitive supportive
18 elements of the clinician-carer interaction" (Huff, Nadig, Ford, & Cox, 2015).
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28 Shared decision-making has been defined as

29
30 *"an approach where clinicians and patients share the best available evidence when faced*
31 *with the task of making decisions, and where patients are supported to consider options,*
32 *to achieve informed preferences"* (Elwyn et al., 2010).
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38 It is striking that this definition does not take APs' presence and influence into account. A
39 realist synthesis of evidence on integrated care for older people with complex needs called for
40 further research on involvement of relatives in shared decision-making (Bunn et al., 2018). A
41 review of studies on triadic medical consultations identified a need for physicians to establish
42 role preferences of patients and companions (Laidsaar-Powell et al., 2013). Such consultations
43 require careful balancing of focus on the patient and inclusion of the companion or family
44 member, and for this, enhanced training for professionals in communication is critical (Cheung
45 & Hocking, 2004; Karnieli-Miller et al., 2012; Manias, 2013). The persuasive conversational
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3 strategies (Boyd, & Heritage, 2006; Roy-Chowdhury, 2006) observed in our study bear witness
4
5 to the challenges, and also the potential for considering APs' views within a shared decision-
6
7 making framework (Elwyn, et al., 2012). In the time- and resource-pressured ED environment,
8
9 enhanced awareness of these issues may enable practitioners to develop more accurate appraisal
10
11 of factors that can affect patients' forward care (Magdelijns et al., 2016).
12
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14
15 The importance of a relationship-centered approach which includes members of the
16
17 patient's social network in decision-making has been emphasized in the literature (Adams &
18
19 Gardiner, 2005; Nolan et al., 2003; Schneider, Scales, Bailey, & Lloyd, 2010). In areas of health
20
21 care such as critical illness, family-centered care (FCC) is a central ethos, with associations
22
23 reported between FCC and reduced family member anxiety (Hamzah & Sukarni, 2017). An
24
25 integrative review of interventions intending to enable family involvement in care of adults in
26
27 acute hospital wards showed favorable impact on patient outcomes in seven studies (Mackie et al
28
29 2018).
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32 33 34 35 *Strengths and Limitations* 36

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38 Our focus on APs in ED settings fills a critical gap noted in the literature (Georgiadis &
39
40 Corrigan, 2017; Fry et al., 2015; Brown, Brett, Stewart, & Marshall, 1998) by providing in-
41
42 depth, context-sensitive analysis of observational and interview data from ethnographic case
43
44 studies. Data were collected from four acute hospitals using different emergency care models,
45
46 with 56 interview participants, and analysis was informed by regular dialog with methodological
47
48 and clinical experts.
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52 The ethnic homogeneity of our sample is characteristic of the south-west England
53
54 demographic. Further research is needed on socio-cultural and geographical variations in the
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3 profiles, relationships and expectations of patients and APs attending hospital emergency
4 services. We did not collect data regarding APs' educational level or health literacy.
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6

7 8 *Conclusions* 9

10 Although contested definitions of carers and their roles have been noted in former research,
11 effective recognition of, and response to, this mutability is still lacking in policy and practice.
12
13 APs in our study reported many different types of relationship with patients and did not always
14 conceive of themselves as carers. APs' conversations with health professionals were influenced
15 by system pressures in EDs as temporary stopping-places with a nationally-established timelimit
16 for decision-making. ED practitioners deployed conversational strategies to enlist APs in caring
17 functions to support discharge.
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19

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21
22 APs' sense of shame or guilt could inhibit them from arguing openly about their limits to
23 caregiving. Even in cases where APs were – seemingly, reluctantly - ‘talked into’ extending their
24 caring roles, health professionals did not follow up APs' expressed concerns or mention support
25 or respite available for carers.
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30 A system-driven practice of talking APs into caring may generate pressure on people who
31 are publicly undergoing shifts in their relationships with patients. There is a risk of negative
32 outcomes for all involved if discharge arrangements fail or re-attendance ensues. In resource-
33 stretched emergency services, interventions to avoid strain on people supporting patients can
34 commence in the ED. By enquiring in an open way about APs' own situations, experiences and
35 needs, health professionals can avoid routinized attribution of patient-carer relationships that
36 may prove socially shaming for APs to contest. Taking a relationship-centered or family-
37 centered approach to caring could aid shared decision-making and attention to APs as clients of
38 health systems in their own right.
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For Peer Review

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3 *Acknowledgements*
4

5
6 We thank Catherine Pope for her comments and contributions to our study, and Jill Pooler for
7
8 her insights that led us to the concept of ‘talking into being’.
9

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11
12 *Conflict of interest: none declared*
13

14 *Funder and disclaimer*
15

16
17 This project was funded by the National Institute for Health Research [HS&DR] (project number
18
19 10/1010/06). This research was supported by the National Institute for Health Research (NIHR)
20
21
22 Collaboration for Leadership in Applied Health Research and Care South West Peninsula.
23

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25
26 The views expressed are those of the authors and not necessarily those of the NHS, the NIHR,
27
28 the HS&DR program or the Department of Health.
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For Peer Review

Table 1

Patient case studies (n=13) involving Accompanying Persons (APs): data from interactions observed in emergency departments at four NHS hospital sites in south-west England, 2013-14

Case	Patient profile [†]	Patient's presenting condition	Admitted or discharged	AP's pseudonym; relationship with patient	Health professionals observed
1	Male, 83, living with wife	Collapse	Admitted	Agnes – Wife	Foundation Year 1 doctor [‡]
2	Male, 73, living in care home	Confusion/funny turn	Admitted	Beatrice - Wife Carol - Daughter	2 junior doctors [§] , registered nurse from care for the elderly team, consultant
3	Female, 70, living alone	Dizzy spell/collapse	Discharged	Doris - Daughter 1 Elizabeth - Daughter 2 Son 1, Son 2 (not cited)	Junior doctor, consultant from care for the elderly team, consultant in charge of ED
4	Female, 24, living with boyfriend	Funny turn	Discharged	Frances - Mother	Junior doctor, consultant
5	Female, 41, living alone	Neck pain	Admitted	Graham - Boyfriend	Registered nurse
6	Male, 75, living with wife	Severe headache	Admitted	Harriet – Wife	Junior doctor
7	Female, 82, living in retirement complex	Fall	Admitted	Ian – Son	ED consultant
8	Male, 83, living with wife	Chest pain	Admitted	Judith - Wife	Junior doctor
9	Female, 86, living with partner	Fall/dementia	Admitted	Kenneth - Partner	2 registered nurses, junior doctor, 2 occupational therapists, consultant
10	Male, 65, living with wife	Query stroke	Discharged	Lucy - Wife	ED consultant, registered nurse

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11	Female, 65, living with husband	Fainting/fall	Discharged	Michael - Husband	Junior doctor
12	Male, 86, living with wife	Chest pain	Admitted	Nancy - Wife	Junior doctor, registered nurse
13	Female, 85, living next door to friend	Breathlessness/leg swelling	Admitted	Olivia - Friend/neighbour	Junior doctor

† All patients in this group were of White ethnicity. South-west England has a higher proportion of White population than many other UK regions (Office for National Statistics, 2011). Seven of the 65 patients in our study self-defined as being of Black and Minority Ethnicity (BME), but their cases did not meet the inclusion criteria for this analysis of AP presence and data from recorded observations as well as interviews.

‡ A Foundation Year 1 (FY1) doctor is one who has graduated in the past year.

§ Since introduction of the NHS Modernising Medical Careers (MMC) program in 2005, a junior doctor is one who is still in training 3 to 8 years post-graduation, and has not yet reached consultant level. The broad designation of junior doctor includes 'middle-grade' levels and Senior House Officers.

Peer Review

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