

Negotiating Goals: Exploring the Dialogue Between Professionals and Patients in Team- Meetings

Bjørg Christiansen¹ & Mirela Slomic²

1. Oslo Metropolitan University, Norway
2. Moer Nursing home, Ås, Norway

Contact: bjorgchr@oslomet.no, Oslo Metropolitan University, Norway.

Abstract

The aim of this study is to explore the negotiation of goals in team meetings with patients within a specialized rehabilitation context: What characterizes the dialogue between professionals and patients in goal meetings? Despite agreement in the literature that the patients' perspectives and participation are significant in goal setting processes, there seem to be few studies on characteristics of the dialogue in such meetings with patients. The data derived from audio-recorded observations of three team meetings with various health care professionals and patients within rehabilitation services. The method can be characterized as a theme-oriented discourse analysis, which is a qualitative method for analyzing how language constructs professional practice. The analysis identifies two main themes: 1. Reviewing goals: from standardized readings to everyday language. 2. Setting meaningful goals. The article discusses characteristics of the patients' participation in the dialogue, and how professionals de-emphasize inherent power inequalities in the negotiation of goals.

Keywords

Patient participation, interdisciplinary rehabilitation, interprofessional team-meetings, meaningful goals, interactional perspective.

Introduction

Within rehabilitation, interprofessional teamwork involves different health and/or social professions who share a team identity and work closely together in an integrated and interdependent manner to solve complex care problems and deliver services (Reeves, Lewin, Espin & Zwarenstein, 2010). The International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) invites and encourages interprofessional cooperation in rehabilitation. The idea is to develop a holistic approach towards patients and to integrate patient care, while considering all aspects of the patients' lives. Thus, one objective is to increase a patient's behavioural repertoire as much as possible within any constraints imposed by disease and impairments. Identification and setting of goals with patients are therefore a core component of the rehabilitation process (Wade, 2009). Still, differences may exist between the professionals' and the patients' understanding of the rehabilitation process. The professionals' contributions are limited in both time and scope. This means that measurable goals are often set for rehabilitation processes, and such goal setting is often perceived as the intended outcome of a specific set of interventions (Alm Andreassen, 2012; Hammell, 2006). For the patients, however, rehabilitation might be recognized as a long-term learning process that enables them to continue their life after trauma, by evaluating and reconsidering their perceptions of qualities in life (Becker, 1997; Romsland, 2009).

Goal setting and interprofessional rehabilitation

Goal setting or goal planning is the formal process whereby members of an interprofessional team, usually in collaboration with patients or their family, negotiate goals. During team meetings the patients' goals, care and treatment plans and progress are the central topics of discussion. The first step is, according to Wade (2009), to establish which goals are important to the patient, as goals are only effective if they are considered desirable by the subject. The shared setting of explicit goals should ensure that all actions taken by the professionals are contributing towards the overall goal. Goals allow for the monitoring of the rehabilitation process, and review of interventions for reaching such goals. Although one important purpose of goal setting is to motivate the patient, it is also suggested that goal setting may contribute to the patients' insight into and acceptance of limited recovery (Wade, 2009). The theoretical underpinning of goal setting in rehabilitation has not been well researched. Some of the research tend to focus on the nature of a goal, which has led to a widely used (and discussed) guidance on setting goals associated with the acronyms SMART or SMARTER: Specific-Measurable-Attainable/Achievable-Realistic-Time Bound- Evaluate-Readjust (Wade, 2009). A critical view is supported in a study which found

Negotiating Goals

that clinicians appeared to make a distinction between SMART goals needed for clinical documentation, and goals identified in the discussion with patients (Parsons, Plant, Slark & Tyson, 2018). Thus, in a wider perspective, goal setting is often seen as a way to provide direction and purpose for rehabilitation, structure interactions and engage and motivate patients in this process (Parsons et al. 2018, Sugavanam, Mead, Bulley, Donaghy & van Wijck, 2013).

There are, however, some challenges concerning this endeavor. Interprofessional meetings are interactional situations based on dialogue between individuals (Mathisen, Obstfelder, Lorem & Måseide, 2016). Conversations between patients and health professionals cannot be dialogues between equals. Professionals are recognized as holding a position of authority, thus setting the agenda for cooperation and language use. Despite a more autonomous and equitable patient role, the basis of a trusting relationship is, according to Grimen (2009), an authority structure that implies that the professional is more competent than the patient. This makes it difficult for patients to challenge professional judgments. Furthermore, health professionals often act as gatekeepers to goods and services that patients need, such as specialist services or disability pension. When patients interact with health professionals, they may become confused and afraid, as, in the case of stroke patients, who may suffer from impaired linguistic and cognitive capacities. Thus, there are limits to the extent to which patients can be true partners in dialogue with professionals (Grimen, 2009). During individual plan processes, according to Slettebø and Madsen (2012), the main responsibility lies with the professionals for facilitating a dialogue that enables the patients to express their needs and goals for everyday life. This requires an awareness of, and listening to, the patients' needs and wishes. An interactional perspective is useful in shedding light on how authority structures between patients and professionals influence the negotiation of meaning in goal meetings.

Characteristics of an interactional perspective

An interactional perspective refers to a pragmatic view on how language use is linked to particular contexts. Thus, language use is a form of practice which create meaning, social identities and statuses (Måseide, 2008). Goffmann (1986) argues that people make sense of social situations by constructing meaning through frames of understanding. Framing works as a "filter" or "membrane" through which general ideas and values of conduct are reworked to apply to a particular encounter (Goffmann, 1986). The framing of interprofessional meetings is, according to Måseide (2011), characterized by rules for professionally, institutionally and socially adequate conduct. How frames for professional roles and performances are expressed depend on the distinctiveness of the situation, which can also open for an informal, personal and humorous tone. A hallmark of professional conduct is the use of institutional category systems such as goal-plans, which allow for mutual understanding and collaboration among professionals.

Previous Research

Although many rehabilitation institutions strongly believe in patient participation (user involvement) in goal setting and care planning, previous research indicates various challenges. Findings in a systematic review showed unclear extent of patient involvement in the goal setting process in stroke rehabilitation. Patients were often unclear about their role in this process, and differed from professionals on how they set goals, and on how they perceived goal attainment (Sugavanam et al., 2013). According to another systematic review, clinicians felt that they did not have the necessary skills to involve patients in decisions about their goals (Rose, Rosewilliam & Soundy, 2017). Some goals tended to be privileged in team discussions and clinical documentation, such as the clinicians' activities and main work responsibilities (Levack, Dean, Siegert & McPherson, 2011). There is a need to consider the impact of prioritizing clinician-derived goals at the expense of patient-identified goals (Parsons et al., 2018). Studies that focus on how communicative strategies by health professionals impact the quality of patient participation have relevance concerning negotiating goals. One example is a study by Bélanger et al. (2016), who found that patients and health care providers in palliative care used a variety of interpretive repertoires to covertly negotiate their roles in decision-making, and to legitimize decisions that shaped patients' terminal trajectories. Studies from Norway, Sweden and the Netherlands showed various challenges concerning goal setting and decision-making processes. Nurses within rehabilitation found it essential to support and inform patients in the process of goal setting and recovery. The nurses perceived that many patients, not only the ones suffering from cognitive impairment, found goal setting challenging (Christiansen & Feiring, 2017). Patients' participation in the interprofessional team meetings was perceived as formal user involvement by rehabilitation professionals and could be perceived as disempowering or even burdening by the patients. Authentic user involvement on the other hand, was primarily expressed through the daily informal contact and interaction between patients and professionals, granting patients an individual voice and choice in practice (Slomic, Christiansen, Sjøberg & Sveen, 2016). Observational studies of interprofessional team meetings (some with patients) showed that even though the meetings were conducted in a friendly consensus atmosphere, the decisions concerning the needs of elderly persons in the municipality were more or less profession specific (Duner, 2013). Professionals did not need to make an extra effort to adapt their language, as avoiding difficult jargon when patients or relatives were involved came naturally (van Dongen et al., 2016). However, another study indicates that difficult language or jargon was not perceived as a barrier by patients and relatives attending team meetings with professionals. Still some patients did not see a need to be present at the meeting and relied on the judgement of the professionals (van Dongen et al. 2017). A study which investigated discharge planning meetings in rehabilitation clinics found that the meeting structure and leading style limited patients' opportunities to participate (Schoeb, Staffoni & Keel, 2018).

Negotiating Goals

Despite agreement in the literature that goal setting and care planning should be central during interprofessional team meetings, and that the patients' perspectives and participation are significant in refining such processes, there seem to be few studies on characteristics of the dialogue in such meetings with patients. In this article, goal meetings are rehabilitation team meetings between health care professionals and patients. In the specialized rehabilitation services where this study took place, the goal meetings focused on patients' goals, progress and plans regarding their rehabilitation process (Regulations on habilitation and rehabilitation, 2019). The meetings with patients were conducted several times during the patient's stay – usually after admittance (setting goals), halfway through the planned stay (discussing progress and reviewing goals), and prior to discharge (planning return to the community).

Based on the following research question the aim of the study is to explore the negotiation of goals in these particular meetings: What characterizes the dialogue between professionals and patients in goal meetings?

Methods

This qualitative study was part of a larger project called "Transitions in Rehabilitation" that explored different aspects of rehabilitation of patients with traumatic brain injury (TBI) and spinal cord damage. Both authors were members of the research group conducting this project. The project also entailed a user panel with representatives from relevant user organizations. The representatives have personal experiences either as patients with TBI or multiple trauma or as next of kin. *Experiential and professional knowledge in interdisciplinary rehabilitation* was one of three focus areas in the Transitions project and was based on observations of eight meetings of interprofessional teams at two specialized rehabilitation units in southeastern Norway, and on semi-structured in-depth post-meeting interviews with 16 participating rehabilitation professionals. The observations and the interviews were completed in April 2016. In this article, however, we focused exclusively on 50 pages of transcripts from audio-recorded dialogue from the interprofessional team meetings where patients participated (three of eight observed meetings).

Participants

The professionals participating in the study were selected based on observations of the meetings where the patients participated. Thus, the included health care professionals were physicians, physical therapists, occupational therapists, nurses and psychologists, as well as team coordinators. The participating patients were suffering from traumatic brain injury or spinal cord injury. The patients' family members did not participate in the meetings included in the present study.

Obs 1	Obs 2	Obs 3
Patient with spinal cord injury (PA)	Patient with spinal cord injury (PA)	Patient with traumatic brain injury (PA)
Physician (PH)	Physician (PH)	Physician (PH)
Team coordinator (TC)		Team coordinator (TC)
Nurse (N)	Nurse (N)	
Physical therapist (PT)	Physical therapist (PT)	Physical therapist (PT)
Occupational therapist (OT)	Occupational therapist (OT)	Occupational therapist (OT)
		Psychologist (PS)

Table 1. *Participants in the observed team meetings*

Data collection

The primary intention of the observation of the interprofessional meetings with patients was to gain access to the dialogue between the participants. Thus, the professionals were observed in a natural working environment, which in these particular meetings was influenced by the participating patients. Observations offer the possibility to observe the context, routines and practices that the participants might take for granted (Patton, 2015). The observer (second author) presented the project to the participating professionals in advance of the data collection in order to familiarize and reduce Hawthorne-effect. The participants seemed to accept the observer (second author) as an interested listener, who did not take an active part in the discourse. The meetings lasted from three quarters of an hour to one hour. The use of an audio-recorder, supplemented by notes, made it possible to gain detailed information about the participants' language and modes of expression, which enabled us to identify subtle nuances of expressed meaning. The audio-recordings were transcribed verbatim by the second author, allowing detailed features of dialogue such as

Negotiating Goals

pauses and non-verbal sounds like “uhm”, sometimes uttered to indicate agreement or understanding.

Ethical issues

The Regional Committee for Medical and Health Research Ethics assessed the study. The notification to the Privacy and Data Protection Officer passed without any objections. Informed written consent was obtained from all the professionals and from the patients who either participated or had their cases discussed during the interprofessional meetings. Recorded files were stored on a secure research server, and only the researchers involved in the project had access to the files.

Analytic procedure

This article draws on verbatim transcriptions of dialogue in three interprofessional meetings with patients. The analysis can be characterized as a theme-oriented discourse analysis, which is a qualitative method for analysing how language constructs professional practice. In institutional encounters dialogue is work. Recordings of naturally occurring interactions are transcribed, and the analytic process sheds light on how meaning is negotiated in interaction (Roberts & Sarangi, 2005). We use theme-oriented in the sense of analytic themes which identify what is talked about, and in what ways (e.g. tone of voice, use of humour, choice of vocabulary). In the analytic process we also draw on Braun and Clarke’s (2006) descriptions of how themes are identified within a semantic approach, and not beyond what a participant has said. We conducted the analysis in accordance with the following phases:

First phase: The transcriptions from each meeting were read several times by the authors to become familiar with the data. This meant a further examination of verbal and non-verbal behavior of individuals, which implied a detailed focus on the meaning and pattern of the utterances and the sequence of dialogue. Resembling an inductive approach, the reading formed the basis for a list of ideas and interesting patterns of meaning, involving the production of initial codes, e.g. talk about goals by the patient, medical wording, addressing the patient, humour, hesitation, persuasion.

Second phase: The data set was subsequently coded systematically by identifying meaning units which demonstrated each code. The coding was done manually, using colored pens, identifying interesting aspects across the dataset. Thus, the data was organized into named meaningful groups.

Third phase: Through “back and forth” considerations about the relationship and belongings of the coded meaning units, the analysis was re-focused at the broader level of themes. Thus, the content of the coded meaningful groups was re-read, compared with other groups and merged into potential themes.

Negotiating Goals

Forth phase involved further considerations which led to a refinement and reduction of initial themes into the following main themes:

1. Reviewing goals; from standardized readings to everyday language
2. Setting meaningful goals

The fifth phase implied a transition from description to a more comprehensive understanding by using theoretical frameworks and previous research moving our analysis to a higher level of abstraction which is reflected in the discussion.

Reflexivity

Any analysis of qualitative data is influenced by the pre-understanding of the researchers. According to Rubin and Rubin (2012), having knowledge of the culture under study is a great advantage, whereas the challenge is to create an analytical distance from the taken-for-granted knowledge. Even if both authors have the same professional background as some of the participants (physician and nurse), we are also researchers, and none of us have practiced at rehabilitation institutions. Although the first author had the main responsibility for the analytical process, data was discussed with the second author throughout the process. According to Brinkmann and Kvale (2015), different interpreters are potential sources of fruitful insights and virtues of qualitative research. To enhance the rigor of the analytical process, the other six researchers from the main project, as well as the user panel, were involved in discussing the analysis.

Findings

The presentation of findings is centered around selected extracts of dialogue from the three team meetings where patients also participated, which illustrate and underpin the main themes. The patients involved in this study suffered from traumatic brain injuries and spinal damage, and the professionals in the meetings were directly involved in their care. Written individual goal plans, often displayed on a screen in the meeting room or available in paper form for the participants, were used to ensure user involvement and progress towards common goals. In the team meetings with patients the discussions between the professionals were downplayed, and their utterances were more unified and supportive, addressing the patient present at the meeting. The meetings were usually chaired by a physician or a team coordinator, often a nurse.

Reviewing goals: from standardized readings to everyday language

In one goal meeting (obs1), with a patient suffering from spinal cord injury, the intention was to review the patient's goals halfway through the planned stay, in order to clarify what had been achieved, and to set new goals and actions for the next four weeks. This was the patient's second goal meeting following several weeks at a specialized rehabilitation unit. In addition to the patient (PA), five professionals participated: physician (PH), physical

Negotiating Goals

therapist (PT), occupational therapist (OT), nurse (N), and team coordinator (TC) (nurse). All participants were seated around a table with a copy of the goal plan in front of them. The team coordinator repeated the agenda of the meeting. After a short reminder of the long-term goals such as “coming home”, “back to work” and the need for home-based leave to gradually adapt to every-day life, the focus turned to the short-term goals. The physician had a chairing role, reading the headlines in the goal plan:

Extract 1:

1. PH: Shall we start with bodily functions and structures? The goals say to keep the skin undamaged and to provide training to prevent bedsores. There have been some challenges ...
2. N, PT, OT (approving): uhm
3. PA: yes, it is -
4. PH: [skin] ... uhm
5. TC addresses the nurse who then refers to a bedsore on the patients back:
6. N: it's healing, so we continue (bedsore - care)
7. PA: bedsores are predictable ...
8. The other professionals approve: yes ...

The headline “bodily function and structure” in the goal plan reflects a standardized medical terminology which take little account of the patient's understanding. The subsequent goals refer primarily to professional actions to prevent bedsores, a complication this patient was exposed to. Although the patient's view is not explicitly asked for, he contributes with short comments, in line with the professional's assessment of goals and actions (line 3 and 7). However, further dialogue also shows how the professionals worked to adjust their interaction in order to involve the patient present: The nurse followed up on specific nursing issues like bedsore-care in a more everyday language:

Extract 2:

1. N: yes, uhm .. and there was a bit of excoriated skin in the fold on the buttocks which is improving (...) it is improving because you changed your mattress, you have been at home and (...) when you move you have become much stronger, that helps a lot, right?
2. PA: uhm ...

Negotiating Goals

3. N: you lift yourself more ..
4. PA: uhm ...
5. N: that helps to prevent new bedsores, avoid skin abrasions while moving (...) but we still have to keep an eye on it

Extract 2 illustrates how the dialogue changed character and became more person-centered, addressing the patient directly and approving his efforts to prevent bedsores.

Next, the team coordinator, occupational therapist and nurse start questioning the patient about how he managed at home when on leave from the hospital. The following dialogue sequence illustrates that even though the readings from the goal plan in a profession-specific language set the scene for the professionals, they simultaneously continue to involve the patient in the dialogue. As the following extract illustrates, this also applies to the next theme in the goal plan; bowel regimen.

Extract 3:

1. PH reads: then there is the bowel regimen with laxatives and routines ...
2. N addresses the patient: here are some changes. You had to stop taking those pills (laxatives), (...) so the next step is that you learn to put ..
3. PA: [mhm], put it (enema) in myself ...
4. N confirms: put it in yourself ..
5. TC adds: Yes, to manage, become independent

Even though the readings of standardized headlines primarily structure the meeting for the professionals, the professionals (e.g. the nurse) continue to address the patient directly in a more everyday language. Changing from a medical terminology to wording adapted to the patient's understanding involves him in the dialogue which proceeds in a fluent and agreeable manner (line 3-4).

Nevertheless, the way the goals and actions were formulated in the goal plan seems to privilege the professionals' mutual understanding, and to a lesser extent the patient's

Negotiating Goals

participation, as exemplified in these sequences from other team meetings: The physician addresses the patient while reading goals from the plan (obs 2):

Extract 4:

1. PH: have knowledge about spinal cord injury
2. PA (in a low voice): yes, that is ...
3. PH continues to read from the plan: take more part in ADL (Activities of Daily Living)
4. PA: What is that?
5. PH: That is self-care
6. PA: Oh, is that what that means

This extract shows how professionals hold a position of authority by their medical wording, which reinforces the asymmetry in relation to the patient, with similarities to a student-teacher relationship.

In another meeting (obs 3) the patient was suffering from traumatic brain injury with epileptic seizures. This short sequence also illustrates medical wording generally used in dialogue between professionals. The meeting was chaired by the team coordinator who read from the goal plan:

Extract 5:

1. TC: examine cognitive function ...
2. PA: mhm ..
3. TC: is ongoing ..
4. PA: mhm

The medical jargon had observable consequences for further dialogue, impeding the patient's possibilities for a more authentic participation.

Setting meaningful goals

Setting relevant and meaningful goals in the rehabilitation process was a main issue in the team meetings. In one of the meetings at an early stage of the planned stay (obs 3) the focus was on a patient suffering from epileptic absence seizures after a traumatic brain injury. Four professionals: physician (PH), occupational therapist (OT) physical therapist (PT), psychologist (PS) and a team coordinator (TC), updated each other on the patient situation

Negotiating Goals

and the goals in the plan before he entered the room. When seated, the team coordinator, who chaired the meeting, addressed the patient:

Extract 6:

1. TC: What do you think is your goal in order to ..
2. PA: My only goal is to get rid of the seizures, wipe them out ...
3. The others: mhm ...
4. PA: that is my only goal ...
5. PS: What about long term goals (...) after discharge? (...) In relation to work, for instance?
6. PA: Yes ...

This extract illustrates how dialogue about goals sometimes was introduced by a patient-centered approach, without initial readings from the plan. In this example the patient's most important goal was to get rid of troublesome symptoms. This was a point of departure for further modification from the psychologist, who tried to expand the perspective on goal setting by asking questions related to everyday life and work after departure.

However, the further dialogue changed character to become more focused on medical needs when the professionals also wanted the patient to take an active part in mapping the frequency of the seizures by using a form to keep track of the seizures. Thus, a sub-goal was defined on behalf of the patient:

Extract 7:

1. PS: It is important for you to get a good overview ... (of the seizures)
2. PA: Yes ... (a low, hesitant voice)
3. While the professionals change the subject, the psychologist, who seems to have noticed the hesitation in the patient's utterance, returns to the registration of the seizures, addressing the patient:
4. PS: Even though we have to map the seizures at present (...) how would you, in the long run, prefer people to relate to the seizures?
5. PA: At present very few people really know ... I've been very good at concealing it ... so I don't know ...

Negotiating Goals

6. PS, OT, PT: Mhm ...
7. PS continues: if people outside this institution should ask you (about the seizures), would it be ok for you to answer?
8. PA: Yes, that's ok ... no problem
9. PS: Mhm ... would you prefer that we (the professionals) ignore the seizures? Or would you be disappointed?
10. PA: It's all the same to me (laughing)

This extract illustrates how easily goals and actions are set by the professionals, without taking thoroughly into consideration the patient's point of view (line 1-2). However, in this case the psychologist proceeded by exploring how the patient perceived the seizures, which differed from what the professionals initially thought. The dialogue also seems to challenge the patient's perception of the social impact of the epileptic seizures, which may constitute the reason for meaningful goals and actions (line 4-10).

The team coordinator proceeds by addressing the patient and the physical therapist:

Extract 8:

1. TC: Have you set any physical goals?
2. PT: We have talked about ..
3. PA (interrupts): Swimming and running (with laughter)
4. PT addressing PA: No, to increase your fitness .. you get easily exhausted
5. PA: Mhm ...
6. PT: You said you have not been particularly physically active before ?
7. PA and the professionals laugh together

Then the physical therapist, in dialogue with the patient and team coordinator, informs about various physical tests they had performed.

Extract 9:

1. TC continues: fitness, strength, balance; maybe you could set some goals ?

Negotiating Goals

2. PT: We haven't completed tests yet that enables him to score ... thought of something more advanced .. testing mobility next week (...) like running and jumping ...
3. TC: Then maybe you can set some goals on this ?
4. PA: yes ...
5. PT addresses the patient: yes, uhm ... on Thursday I will arrange a walking-test, wasn't it? Then you walk as fast as you can for six minutes ... this is also a test, and maybe a goal as well, to perform better ...
6. PA and the professionals: Uhm ...
7. PT summarizes: We have not set any measurable goals yet

Extract 8 and 9 show how the physical therapist takes a leading role, primarily stressing various physical tests and goals that allow for measuring physical progress. The patient's view on personal goals and means to achieve better physical fitness, and how important this was for him, was not asked for, and activities like swimming and running introduced by the patient were not elaborated further.

There were, however, further variations concerning the setting of meaningful goals. In extract 10, the patient participates more explicitly when he approves a goal he saw as important in a more long-term perspective, outside the institution. The goal meeting took place halfway through the planned stay (obs 1), and the focus was on to what extent the patient, suffering from Spinal cord injury with paralysis of the legs, was able to get up from the floor and into a (wheel)chair:

Extract 10:

1. PA: that is a goal ..
2. PT adds: A new goal (...) from the floor to the chair ...
3. PA contributes with further contextualization: to be able to reach the telephone (...) the (safety) alarm does not have coverage.

This was a skill the patient should master well in advance of discharge, in order to be somewhat independent. However, the dialogue changed character when the professionals continued to pursue their goals for the patient's further progress. The intention was to motivate the patient to try to stay in his/her home for a while. Such a home stay is part of the rehabilitation process to tailor further support at a future return to community. Several goals and actions were suggested in order to motivate for a short stay at home:

Negotiating Goals

Extract 11:

1. TC addressing the patient: to experience what it is like to stay at home ...
2. PA: Mhm
3. PT: It is also possible with an extra day during the weekend ...
4. PA, in a humorous tone: Maybe it's all right to get rid of me for a bit here?
(Everyone laughs)
5. This utterance was followed by several comments from the professionals, including the nurse:
6. N: more responsibility for the things that go better and better (...) but it's clear, there are some things you need help with, such as with the morning care (...)
7. TC: Home-based nursing ...
8. The encouragement from the nurse was colored by her knowledge of the patient:
9. N: You have so many resources, what you want to achieve is what you get, right?
10. PA: Yes, no ... I manage, but it takes somehow a little extra time ...

Even though goal setting was not explicit, the extract shows how professionals pursue actions they believe are in the patient's best interest concerning the patient's ability to gain independence in daily tasks at home. While the patient signaled hesitation through minimal responses and skeptical humor, the professionals continued to push forward by appealing to his resources and coping ability, combined with professional assistance to support him during the home stay.

Discussion

Characteristics of the dialogue

Interprofessional team meetings are important arenas for the patients to take a direct part in decisions concerning their rehabilitation process, not least in setting and reviewing goals. Our study shows how such processes may take place. As with findings in other studies (Tyson, Burton & McGovern, 2014; Slomic et al., 2016) rehabilitation (goal) plans provide a standardized structure for the observed meetings and serve as a point of departure for the dialogue in the meetings, usually chaired by a physician or a team coordinator. As an

Negotiating Goals

institutional category system (Måseide, 2011, Goffman, 1986), the standardized structure work as a framing of the goal-meetings in accordance with rules for professionally, institutionally and socially adequate conduct. Thus, the initial readings from the goal-plan should secure an overall perspective on the patient's situation and serve the mutual understanding and collaboration among the professionals. Even though the professionals in our study aimed at patient participation and user involvement (Becker, 1997; McPherson, Kayes & Kersten, 2014; Parsons et al., 2018; Sugavanam et al., 2013), the dialogue with patients was influenced by standardized formulations and wording generally used in exchanges between professionals. Previous research found that interprofessional team meetings were perceived by the professionals as an arena for formal user involvement (Slomic et al., 2016). Contrary to findings in another study, (van Dongen et al., 2016), the professionals did not avoid difficult jargon when patients were involved. There were several examples of how readings from the goal plan created language barriers, referring to professional goals and actions such as "to take more part in ADL" (Activities of Daily Living) and "examine cognitive function". Language barriers affect authority structures in relationships with patients, implying that the professionals are more competent than patients. Grimen (2009) points at a system of structural imbalances between professionals and patients, necessitating teaching in physician-patient interaction, as a more educative role. Even if the patient asked for clarification of one of the goals, one cannot expect that patients always express their lack of understanding in meetings with professionals.

Måseide (2008) claims that patients who participate in team-meetings not only conform to frames built into such situations, but also influence how professionals express themselves. Thus interaction between patients and professionals has to be understood as situated, discursive processes which may affect established authority structures (Måseide, 2008). Our study shows that although the professionals adhered to their mutual understanding and functions in the dialogue about goals, they simultaneously worked to adjust their interaction to the patient present. In order to facilitate a common language (Slettebø & Madsen, 2012), the professionals interfered with the initial framing (Goffman, 1986) of the meetings when they made extra efforts to secure the patient's understanding and participation. This was particularly manifest when they changed their choice of wording, explained medical terminology and proceeded in a more everyday language. As exemplified by the nurse, the patient was addressed directly, and medical, intimate themes introduced by the physician were followed up in a patient-centered, concrete way (extract 1: line 6 and extract 2). According to a study from a rehabilitation context, nurses had experienced that patients may have trouble understanding what professionals mean when talking about setting goals. To overcome this, the nurses used different or more specific words to help the patient understand. The younger generation of patients seemed, however, to be more familiar with the goal terminology (Christiansen & Feiring, 2017).

Negotiating Goals

Additionally, during the meetings while in direct dialog between the patient and individual professionals a more precise knowledge of what the patient expressed during earlier one-to-one sessions with that particular professional was shared with the team. This might to a certain extent compensate for possible difficulties for the patient in expressing personal goals in interprofessional meetings.

The dialogue at the meetings was also characterized by a humorous tone, most often initiated by the patients with self-ironic comments which triggered common laughter (extract 7: line 10, extract 8: line 6-7, extract 11: line 4). Thus, humor may to some extent de-emphasize inherent authority structures and promote an open atmosphere, making it easier to talk about difficult topics. Referring to a work context, Holmes (2000) found that humor, especially in unequal encounters, may also function as a strategy used by subordinates to license challenges to the power structures within which they operate. Other studies have focused on how the use of humor may promote positive interactions between provider and patient, and that humor is crucial for maintaining the human dimension of health care (Dean & Major, 2008). Humor was, from the patients' perspective, considered as integral to their experiences with health-care staff as well as other patients and had an impact on how they cope and assert their identity at a time of challenge and crisis (McCreaddie & Payne, 2014).

Features of goal negotiations

Setting and reviewing goals were main issues at the meetings. Even though the patients expressed their goals and desires, the professionals expanded the patients' perspectives on goals by asking questions related to everyday life after departure, as exemplified in extract 6. Thus, they supported the patients in understanding their condition as well as their ability to set goals. Previous research also found that the treating team had a leading role in goal setting meetings; there was rarely a straightforward translation of patient wishes into agreed-upon goals (Barnard, Cruice & Playford, 2010). However, our findings show variations in how the dialogue concerning goals proceeded. In one meeting, a physically disabled patient contributed to further contextualization of a goal proposed by the professionals, concerning his ability to get up from the floor into the chair. The patient emphasized that being able to get up from the floor would enable him to reach the telephone when the safety-alarm had no coverage, which probably added meaningfulness and motivation for practicing this skill (extract 10). Goal setting should include in what situation the patient needs the specific knowledge and skills (Christiansen, 2020).

Assessment of outcomes within rehabilitation ought to focus on the effect of interventions on the clients' lives (Hammell, 2006). Nevertheless, goals defined as intended outcome of interventions might not represent the perspective of the patient. Måseide (2008) claims that problems that belong to the patient's lifeworld can become invisible within the use of institutional category systems. In order to achieve authentic patient participation (Slomic et al., 2016), our study shows the importance of being responsive in the dialogue, as it is easy

Negotiating Goals

to override the patients' experiences and concerns in the process of setting goals and actions. When the psychologist noticed the vague hesitation from the patient concerning the proposed goal to map his seizures, he continued to explore the patient's point of view (extract 7). This is not an obvious communicative skill among health care professionals. A study with focus on the interaction between patients and physicians found that physicians may resist, or fail to recognize and explore, the patient's subtly voiced perspectives and concerns (Landmark, Svennevig, Gerwing & Gulbrandsen, 2017).

The concept of privileged goals, (Levack et al., 2011), is relevant when goals are primarily set on the professionals' terms. The sequence of dialogue between the physical therapist and the patient illustrates how measurable goals, framed within the existing test- and training program at the ward, were emphasized with little consideration for the patient's initial preferences concerning physical activities (extract 9). The link between short term goals of physical fitness assessed by walking-tests, and activities of running and swimming suggested by the patient, was not followed up by the physical therapist. Outcome measurements within rehabilitation have traditionally focused on functional achievements, reflecting normative values of their developers and users. The impact and outcome of rehabilitation cannot be derived from the viewpoints of service providers, but by asking what outcomes are important to clients (Hammell, 2006). Other studies within rehabilitation seem to underpin that this is not always evident. Focusing on the alignment between clinical outcome measures and patient-derived goals related to chronic low back pain, findings showed that clinical outcome measures often remain limited in capturing patient goals (Gardner et al., 2015). Within stroke-rehabilitation, written goals inevitably focused on what clinicians deemed to be achievable within the scope of the services they provided (Levack et al., 2011).

Interprofessional team meetings have, according to Måseide (2011), an emergent rather than determined character, meaning that the ongoing dialogue may create its own way, beyond what was planned or expected. The way meanings and intentions are expressed may not be captured by the other participants, and how the dialogue will end is not given in advance.

As with findings in our study, this issue is particularly relevant when patients are present. One sequence of dialogue showed how the professionals pursue goals and actions when they motivated the patient to participate in activities that could advance the rehabilitation process, such as to try to be at home for a few days (extract 11). The potential home stay was not introduced as a dialogue for potential goal setting related to everyday life, but as a suggestion in the patient's best interest. Thus, the dialogue was characterized by few questions, merely suggestions and supportive utterances from three professionals (nurse, team coordinator and physical therapist), while the patient was signaling resistance. When the patient hesitated, a potential timeframe with assistance from home-based nursing was offered. Earlier research found that it was uncommon for patients to communicate their

resistance using direct language; dissent was often communicated indirectly through minimal responses and humor. A notable effect of minimal response formats was that they often resulted in further dialogue (Barnard et al., 2010). This also applies to our study, where the patient responded to the suggestions with minimal utterances like “mhm” and humor in a skeptical manner. Even though the professionals followed up by appealing to his coping ability combined with support from home-based nursing, there was still a perceptible insecurity in the patient’s final response.

Conclusion

Goal setting is seldom a simple, straightforward process. Even though the patients influenced the setting and reviewing of goals, language barriers occurred when medical jargon and readings from the goal plans threatened an atmosphere of equivalence. However, our study shows the importance of communicative and pedagogical competences in de-emphasizing inherent power inequalities and secure the patients’ authentic participation in the negotiation of goals. In addition to adapting the language, this also requires a sensitivity and eagerness to explore the patients’ point of view, as well as capturing any signs of the unvoiced. Further studies should also address this issue in a long-term perspective when patients are discharged from hospitals to community care.

Discussion of limitations

Observation with audio-recordings enabled us to reveal nuances in the dialogue between professionals and patients in three goal meetings at two rehabilitation wards. Observational studies using naturally occurring data have the advantage that the interaction is not specifically set up for research (Drew, 2005). Video-recordings could have provided an even richer data material, but for ethical reasons this was not considered. A different study design, which also included data from interviews with the professionals, could have been chosen in order to explore the professionals’ perceptions of goal-setting processes with patients. Our findings may have relevance in other health care contexts where professionals and patients are involved in goal-setting processes, because the interactional sequences, according to Peräkylä (2004), illustrate possible practices in real-life interactions. The extensive data material in the main project has made it possible to illuminate other aspects of interprofessional rehabilitation and user involvement (Slomic et al., 2016; Slomic, Sjøberg, Sveen & Christiansen, 2017).

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