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Evolving Roles and Structures of Triadic Engagement in Healthcare

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Purpose

This study focuses on the changing nature of healthcare service encounters by studying the phenomenon of triadic engagement incorporating interactions between patients, local and virtual networks and healthcare professionals.

Design/methodology/approach

An 18-month longitudinal ethnographic study documents interactions in naturally occurring healthcare consultations. Professionals (n=13) and patients (n=24) within primary and secondary care units were recruited. Analysis of observations, field notes and interviews provides an integrated picture of triadic engagement.

Findings

Triadic engagement is conceptualised against a two-level framework. (1) The structure of triadic consultations is identified in terms of the human voice, virtual voice and networked voice. These are related to: companions' contributions to discussions and the virtual network impact. (2) Evolving roles are mapped to three phases of transformation: enhancement; empowerment; emancipation. Triadic engagement varied across conditions.

Research limitations/implications

These changing roles and structures evidence an increasing emphasis on the responsible consumer and patients/companions to utilise information/support in making health-related decisions. The nature and role of third voices requires clear delineation.

Practical implications

Structures of consultations should be rethought around the diversity of patient/companion behaviours and expectations as patients undertake self-service activities. Implications for policy and practice are: the parallel set of local/virtual informational and service activities; a network orientation to healthcare; tailoring of support resources/guides for professionals and third parties to inform support practices.

Originality/value

Contributions are made to understanding triadic engagement and forwarding the agenda on patient-centred care. ~~We offer l~~Longitudinal illumination of consultations is offered through an exceptional level of access to observe consultations.

Keywords

Healthcare, triadic engagement, empowerment, emancipation, consultations

Introduction

'I would look at all avenues, so I'd talk to the consultant, he would set up an appointment with another specialist, but in the meanwhile, I would go onto the Internet and then I would look at written work, I would look at blogs to see if other people with similar conditions have had it, how have they reacted to a particular kind of treatment and were they positive.'

(Diabetes Patient discussing influences they bring to the consultation)

It is increasingly acknowledged that the delivery of healthcare services should be a collaborative effort between professional partners in the health value chain, patients and their wider care network to facilitate more effective treatment outcomes (Hammerschmidt ~~et al.~~*et al.* 2012, McColl-Kennedy ~~et al.~~*et al.* 2017). Engaging people in this way can realize better quality healthcare, improved efficiency in healthcare service provision, and improved health for society (Gregory 2008, Wolff ~~et al.~~*et al.* 2015). As such, engagement roles in healthcare service encounters involve a wider circle of actors, extending the traditional dyadic engagement typically associated with consultations. Further, the fragmentation of healthcare and reduced opportunities for professionals, patients and carers to develop long-term relationships increases reliance on other sources of information and support (often virtual) that can compete with formal services (Keeling ~~et al.~~*et al.* 2015). For instance, the notion of 'carers' has now come to comprise virtual (e.g., other patients with the same condition) and local networks (e.g., family members or friends).

However, it has become clear that the development of roles and structures that enable engagement of multiple stakeholders in service encounters is considerably complex (Swinglehurst ~~et al.~~*et al.* 2014; Pinho ~~et al.~~*et al.* 2014) and that the deployment of these roles and structures varies, depending on the nature of condition(s) (Wolff ~~et al.~~*et al.* 2015). Furthermore, it is relatively poorly understood how the renegotiation of new roles and structures takes shape across various stages and conditions in the healthcare delivery process (i.e., from initial diagnosis to longer term health maintenance) (Clayman ~~et al.~~*et al.* 2005; Spanjol ~~et al.~~*et al.* 2015). Thus, there is a need for developing a more in-depth understanding of the nature of triadic engagement, incorporating how the engagement roles of patient, carer and professional, and engagement structures develop over time, across multiple encounters and across different health conditions.

To enrich ~~our~~ knowledge of triadic engagement as a dynamic unfolding concept, ~~we draw from~~ an emerging body of theorizing on the engagement of multiple participants in healthcare services is utilized. Several authors have argued that triadic engagement holds a definite promise for (cost)-effective healthcare delivery. For instance, there is initial evidence that the presence of a third person in the consultation (or as a virtual presence) significantly improves patient engagement and understanding as well as aiding the professional (Basu ~~et al.~~*et al.* 2010, Keeling ~~et al.~~*et al.* 2015, Wolff ~~et al.~~*et al.* 2015). Yet, at the same time, while enjoying a sharp increase in interest from scholarly exploration across different domains, insights on the concept of triadic engagement remain fragmented and a subject of much debate. For example, in previous research triadic consultations have been routinely excluded from analysis and labelled as 'contaminated' (Ishikawa ~~et al.~~*et al.* 2005). Moreover, a comprehensive review of triadic consultations reveals conflicting results across studies across a large range of aspects (Laidsaar-Powell ~~et al.~~*et al.* 2013). Consequently, this limits ~~our~~ knowledge on the impact of carers on consultations (Wolff ~~et al.~~*et al.* 2015).

This paper sets out to advance ~~our~~ understanding of triadic engagement in the context of healthcare service research by offering three substantive contributions. First, and most fundamentally, the research to date offers little guidance on the conceptualization of triadic engagement in consultations. Adapting a definition of dyadic engagement (Tomasello ~~et al.~~*et al.* 2005), ~~we initially define~~ triadic engagement is initially defined as a, ‘sharing of emotions and behaviours, by means of interaction and mutual response between 3 voices or agents with joint attention on an object or goal’. ~~We t~~Thus, the premise is adopted ~~the premise~~ of triadic engagement as a social exchange process that is characterized by the engagement roles taken by the three voices (Bowers ~~et al.~~*et al.* 2010; Thomas and Bebbington 2005). Furthermore, as these multiple voices join the process of (social) exchange new engagement structures develop, varying from simple, unidirectional exchanges to three-way conversations to a shared leadership structure (Carman ~~et al.~~*et al.* 2013, Gregory 2008). Accordingly, as a first contribution, ~~we advance~~ a conceptual framework for triadic engagement is advanced that is based on the interplay between engagement roles and structures.

Second, the notion of triadic engagement as a social exchange process between multiple stakeholders necessitates the adoption of a dynamic perspective that enables monitoring how engagement roles and structures take shape over time. Such a perspective acknowledges the realities of a more elaborate social exchange, for example, by tracing how medical professionals adapt from a prescriber to a collaborator role, or patients’ and carers’ engagement roles change from passive information recipient roles to those of active contributors (Smith ~~et al.~~*et al.* 2015). A ~~We~~ contribution~~e~~ is made to a more in-depth understanding of triadic engagement in healthcare service encounters by identifying which factors facilitate or inhibit the trajectory of engagement roles and structures during extended periods of treatment and the patient's experience.

Finally, ~~we~~it is recognized that heterogeneity in the development of triadic engagement can be observed across different conditions. Commonly, chronic conditions are distinguished from acute conditions. Acute conditions are restricted to one bodily function and the response to treatment is relatively short term (Spanjol ~~et al.~~*et al.* 2015). Conversely, chronic conditions involve multiple systemic causes and medical specializations and have an uncertain future. They also commonly require more resources and self-management by patients to maintain or adapt lifestyles. As a third contribution, it is~~we~~ examined whether triadic engagement roles and structures differ across these two generic classes of conditions. ~~We also include a~~A multiple conditions category is also included reflecting the reality that patients with chronic conditions can also suffer with mental health issues (e.g., depression).

In the remainder of the paper, ~~we first develop~~ a guiding framework is first developed for understanding triadic engagement based on two key conceptual themes of engagement roles and engagement structures. Following an explanation of the methodology, ~~we present our~~the findings are presented around triadic engagement structures and roles. ~~We~~ In conclusion, ~~conclude by drawing our~~the findings are drawn together into an explicated framework and reflecti~~ng~~ons offered on the implications for developing theory on triadic engagement and for developing healthcare delivery.

Conceptual Development

Triadic consultations

The trend in contemporary healthcare practice, which is driving the healthcare service research agenda, is towards developing a patient-centred care approach to service delivery that enables integration of a triad of stakeholders (i.e., patient, professional and carer) (Cosgrove ~~et al.~~*et al.* 2013; Danahar and Gallan 2016). There is clear evidence from extensive research into dyadic consultations that the balance of power has most often been in favour of the medical professional (Sakai and Carpenter 2011). However, there is an increasing recognition that dyads are an artificial situation, as engagement in healthcare services encounters is not exclusive to the patient and the clinician. Rather, it is inclusive encompassing the wider (virtual) network, whom patients and professionals often rely on (Price ~~et al.~~*et al.* 2012). That is, ill health is not only biological but also social.

Family, friends and acquaintances can have an extensive influence on patient's outlook and choices. For instance, Verleye ~~et al.~~*et al.* (2014) demonstrate the importance of engagement behaviours of significant others in the context of nursing homes. Furthermore, a recent study (Ponsignon ~~et al.~~*et al.* 2015) developed a framework of the healthcare quality experience of cancer patients and their carers and demonstrates that this drives satisfaction and referrals. Also, over a third of cancer patients (33.9%) mention family members, friends, and co-workers as a key source of health information (Lewis ~~et al.~~*et al.* 2009). Indeed, there is clear evidence that triadic consultations are rapidly becoming a more common occurrence, with estimates of up to 60% of consultations including a third person (Karnieli-Miller ~~et al.~~*et al.* 2012). As a consequence, carer engagement is already formulated within the patient-centred care paradigm (Wolff ~~et al.~~*et al.* 2015).

A triad is broadly defined as "an interaction of three people or voices", where voice is meant both literally "as the human voice" and metaphorically as "the distinctive style and authority that a text has" (Swinglehurst ~~et al.~~*et al.* 2014, p.2). This use of the term voices is significant to the potential composition of a triad, as a voice can be a physical person (e.g., a carer or interpreter) or other influences, such as technologies (e.g., a computer in the room) or virtual influences (e.g., information gathered from an online resource). With regards to a physical presence, observations of consultation triads in the form patient-professional-companion demonstrate that a third person can aid in professional and patient understanding of conditions and treatments, encouraging the patient to become more active in the conversation (Wolff ~~et al.~~*et al.* 2015). With regards to other influencing voices, observations of consultation triads in the form of patient-professional-computer demonstrate disruption to the normal rules of dyadic interaction due to the presence of a computer (or other technologies, such as Electronic Patient Records) (Dey ~~et al.~~*et al.* 2013; Dowell ~~et al.~~*et al.* 2013, Pearce ~~et al.~~*et al.* 2011, Swinglehurst ~~et al.~~*et al.* 2014).

Importantly, the 'virtual voice' has also been shown to play an important role in conversations (Adelswärd ~~et al.~~*et al.* 2002). Virtual voices may be reports of what 'others have said' (e.g., through online forums), a hypothetical view introduced into the conversation, or specific references to content or opinions from a variety of media (Yao ~~et al.~~*et al.* 2015). Multiple virtual voices can enhance discussion over difficult topics as well as strengthen arguments of those present in a conversation (Adelswärd ~~et al.~~*et al.* 2002; Van Oerle ~~et al.~~*et al.* 2016). As such, the voices, potentially competing, present in the consultation must be seen as an entity, or 'triadic alliance', and a plural perspective adopted to understand the influence of the actors (Pierrehumbert and Fivaz-Depeursinge 1994, Tates and Meeuwesen 2001).

With increased third voice inclusion, the dynamics of healthcare interactions become more complex. Triadic consultations give rise to more elaborate social exchanges and new configurations of voices emerge (in terms of knowledge, power, authority and social identities), even the loss or marginalisation of the patient voice (Sakai and Carpenter 2011, Swinglehurst ~~et al.~~*et al.* 2014). Interactions between multiple voices can be conceptualized as a social exchange process (Thomas and Bebbington 2005). That is, a 'messy' discussion that recognises the potential for power imbalance, confrontation, and the need to accept other perspectives. In this exchange process those who play a role commit to "learn something of the worldview of the other … address structural issues that constrain them and collectively they strive to create some better outcome" (Bebbington ~~et al.~~*et al.* 2007, p.364).

Bringing a third voice to the table may present the challenge of dealing with an intermediary between patient and professional. They might fulfil a supportive role, as a communication buffer, answering questions, empowering the patient to be more involved in the consultation (van Staa 2011, Wolff et al, 2013). Conversely, a third party can play an inhibitory role, by filtering information, questioning legitimacy of advice, or disconfirming patients' explanatory models of illness (Lewis ~~et al.~~*et al.* 2009). As such, triadic consultations offer the potential for not only cooperation but also conflict, especially where mismatches in expectations occur around role and input into decision-making (Laidsaar-Powell ~~et al.~~*et al.* 2013). Further, different tactics are used by the professional, patient and third person in attempts to focus the discussion on their perspective (Sakai and Carpenter 2011), body and gaze modalities are altered (Pierrehumbert and Fivaz-Depeursinge 1994), and not all triads are truly inclusive (Karnieli-Miller ~~et al.~~*et al.* 2012). These significant changes in healthcare consultations necessitate further conceptual development of engagement as a triadic phenomenon, focusing on shifts in engagement roles and structures.

The foundations of engagement

Conceptualisation of engagement has grown rapidly over the past decade (Venkatesan 2017) and is associated with the experience of interaction (Hollebeek ~~et al.~~*et al.* 2016). For example, Brodie and colleagues (2011, 2013) point to engagement as a 'psychological state induced by the individual's specific interactive experience with a focal engagement object' (Brodie ~~et al.~~*et al.* 2011, p. 258). Within the context of healthcare, the focal object may be a person (e.g., a healthcare professional) or a condition (e.g., diabetes) or an online resource (e.g., a healthcare forum). The marketing and care literatures converge on engagement as three-dimensional with cognitive, affective and behavioural components with a central role in exchange (Brodie ~~et al.~~*et al.* 2013, Carman ~~et al.~~*et al.* 2013, Hollebeek ~~et al.~~*et al.* 2014, Wolff ~~et al.~~*et al.* 2015).

Within the healthcare context, cognitive engagement refers to an actor's understanding of the consultation's goals and how they can contribute to achieving these. Cognitive engagement is instrumental to the performativity of the processes by which desired outcomes of the consultation are achieved. A third voice can be instrumental in cognitive engagement through opening up feedback, reflection, multi-voice interaction and problem-solving (Borders 2012, Laidsaar-Powell ~~et al.~~*et al.* 2013, Sharp and Hobson 2016). Affective engagement, refers to an actor's emotional reaction to a consultation as an outcome of a cognitive appraisal, such as, 'what are the implications of this advice for my wellbeing?' From a patient's perspective, affective engagement encompasses both their emotional reaction to and level of acceptance of a condition (Graffigna ~~et al.~~*et al.* 2016). From a care perspective, the third voice is integral to a patient's emotional support, both in consultations and daily life (Laidsaar-Powell ~~et al.~~*et al.* 2013, Sharp and Hobson 2016). Indeed, triadic consultations can help reduce defensiveness (Borders 2012). Carman ~~et al.~~*et al.* (2013) argue that behavioural engagement in care manifests in the patient (and carer) active voice in decision-making around care. Although, this necessitates that the patient (and carer) has the behavioural skills to manage their health experiences (Graffigna ~~et al.~~*et al.* 2016).

Engagement should be distinguished from concepts such as participation or involvement. The former focuses on level of activity and the latter on level of allocated cognitive resources (Abdul-Ghani ~~et al.~~*et al.* 2011, Mollen and Wilson 2010); both having been distinguished as antecedents and/or consequences of engagement (Brodie ~~et al.~~*et al.* 2013). Further, both involvement and participation focus on specific, one-time activities or exchanges (such as one consultation); rather engagement is a longitudinal and wider reaching terms to include a patient's engagement with the whole process of formal and informal care (Graffigna ~~et al.~~*et al.* 2016). Hollebeek (2011) supports the notion that engagement is iterative, that is, the consequences of engagement (e.g., empowerment) become antecedents of subsequent engagement and so forth. As the scope of healthcare encounters is widening, patient engagement researchers argue for a continuum of progressively more immersive engagement. Studies of triadic and group consultations observe that multi-voice engagement developed levels of self-awareness as well as encouraging those involved to give and receive feedback (Borders 2012). That is, increased engagement stimulated more meaningful interactions about care over time amongst multiple voices. Within this extended scope, it is relevant to distinguish between triadic engagement roles and engagement structures.

Triadic engagement roles

Customer engagement theory recognises the importance of the contribution of resources that individuals offer, distinct from and complementing the resources of the firm or organisation (Harmeling ~~et al.~~*et al.* 2017). Bowers ~~et al.~~*et al.* (2010) argue that as engagement develops so the patient's role flows from a transactional (passive) through a transitional (learning to be more active) to a transformational (active and equal) role. The transformation of roles is supported by the sub-processes of learning, sharing, advocating, socializing and co-developing at various levels (Brodie ~~et al.~~*et al.* 2013; Beirão ~~et al.~~*et al.* 2017). Evidence within the healthcare context finds such processes to underpin (re)negotiation of roles whereby patients (with carers) progressively take more responsibility (and ownership) for the direction and nature of their care (Keeling ~~et al.~~*et al.* 2015). As Sharma and Conduit (2016) show in respect to healthcare organizations, supportive cocreation behaviours stimulate the interactive nature of cocreation with a focus on shared decision-making. For instance, within the domain of child healthcare it is argued that the use of triadic engagement holds the promise of improving shared decision making, which in turn has positive implications for traditional healthcare outcomes (Brown and Woods 2016).

Recent thinking postulates that stakeholders in healthcare should aim to achieve enhancement, empowerment and, ultimately, emancipation (Botin and Nøhr 2016), through means of engagement, empathy and enactment (Botin ~~et al.~~*et al.* 2015). Enhancement and empowerment can be reached by the support of physical/organisational infrastructure, processes and technology, whereas emancipation requires an act of will and knowledge of the individual (Botin and Nøhr 2016). That is, the structure of formal service delivery can only support the transformation process so far. This level of emancipation is observed in patient forums, where healthcare decisions were owned by the individual and not the professional (Keeling ~~et al.~~*et al.* 2015) and a sense of social identity drives patients' value co-creation (Zhao ~~et al.~~*et al.* 2015).

Triadic engagement structures

Building on Vargo and Lusch (2016) who emphasise that co-creation is generated within an ecosystem with defined structures, Hollebeek ~~et al.~~*et al.* (2016) point to the importance of the social aspect of customer engagement recognising that people are embedded within a network. Adopting a triadic engagement lens emphasises the need to map the nature of interactions inside the (triadic) consultation and those outside of the formal healthcare setting that may manifest as a virtual voice within the consultation (Pierrehumbert and Fivaz-Depeursinge 1994, Verleye ~~et al.~~*et al.* 2013). Further, there is a need to develop knowledge frameworks that shift mind-sets towards viewing consultations as co-constructions (i.e., that all participants have an active role in a conversation), and move practice to a more inclusive model to achieve true triadic encounters bringing all voices into focus (Swinglehurst ~~et al.~~*et al.* 2014). Researchers argue that interactions within consultations develop over the course of multiple events, starting with a simple exchange structure through a conversation structure and finally to a shared leadership structure (Carman ~~et al.~~*et al.* 2013, Gregory 2008). This is similar to McColl-Kennedy ~~et al.~~*et al.*'s (2012) and Spanjol's (2015) notion of practice styles in the co-creation of value in health. The critical requirements to allow such development of a social exchange process include the possibility for human agency, facilitating institutional frameworks, accessibility of meaningful language, and a redefinition the role of experts (Bebbington ~~et al.~~*et al.* 2007, Vargo and Lusch 2016). As such, the triadic consultation structure is the first building block providing the platform for interactions that enable (or otherwise) inclusive, equitable roles within healthcare, incorporating multiple voices (Winton 2010).

If consultations are to become structures that support shared leadership within healthcare, then the challenge of engagement is to effectively integrate the voice (and choice) of patients and companions into all aspects of healthcare. In the last century, Gallessich (1985) recognised that the common ideologies or value systems underpinning consultations were often determined by the expert but are rarely articulated. Whilst there is potential for consultations to be collaborative and democratic, the prevailing model is still paternalistic (Hardyman ~~et al.~~*et al.* 2015). To achieve the engagement of all stakeholders necessitates a change in traditional consultation structures. From a policy perspective, this means moving from a paternalistic to a patient-centred or egalitarian perspective (Luxford 2013, Tates and Meeuwesen 2001). From an individual perspective, professionals must move from prescriber to collaborator, from face-to-face to technology-infused service encounters, the patient and carer from passive recipient to active participant (Smith ~~et al.~~*et al.* 2015; Green ~~et al.~~*et al.* 2016; McColl-Kennedy ~~et al.~~*et al.* 2017). Yet, professionals may struggle with changing structures whether through a lack of clarity, skills or understanding, physical/organisational infrastructure or, motivation (Happell 2010). At the same time, technology has enhanced the engagement of both patients and their support network in healthcare (Ricciardi ~~et al.~~*et al.* 2013). Consumers are more proactive in their health self-management through use of online resources, for example, to support adherence to treatment plans (Greenspun ~~et al.~~*et al.* 2015).

A framework for triadic engagement

Recent arguments strongly support conceptualizing patient engagement as a broad, overarching concept (Graffigna ~~et al.~~*et al.* 2016). In line with this argument and in synthesising the two broad themes from the literature, ~~our~~ the starting framework (see figure 1) indicates that triadic engagement can be understood as an evolving interactive process composed of developing engagement structures and roles. For example, a third voice will likely affect the structure of and relationship between the patient and professional as well as the nature of that exchange, ultimately impacting the outcomes of the consultation process in terms of understanding and agreement (Karnieli-Miller ~~et al.~~*et al.* 2012). Further, it is argued that the triadic consultation, or "crowded consultation", is a meeting of voices likely to encourage more of a collaborative or co-constructed consultation necessary for patient-centred care (Basu ~~et al.~~*et al.* 2010, Swinglehurst ~~et al.~~*et al.* 2014). It is proposed, as indicated in figure 1, that to realise the benefits of triadic engagement, ~~we also need~~it is also necessary to understand how the structure and adopted roles can be aligned as they develop. For example, promising results arise in the use of purposeful triadic interventions, such as a more inclusive and educational series of consultations when compared with traditional practices (Salisbury and Cushing 2013). Conversely, others have found confusion over the role of the third person in a consultation (Karnieli-Miller ~~et al.~~*et al.*

2012), indicating a need to explicate more carefully the alignment of triadic structures and roles across different health conditions.

Figure 1: A Framework for Triadic Engagement

In the next section, ~~we discuss~~ the results of an ethnographic study are discussed that takes this framework as a reference point for examining how triadic engagement in healthcare services encounters develops over time to identify the factors that facilitate or inhibit the trajectory of engagement roles and structures during extended periods of treatment and across different health conditions.

Methodology

The research focuses on four condition categories representing acute and chronic conditions: breast cancer, prostate cancer, types 1 and 2 diabetes and multiple conditions (incorporating mental health). Full ethics approval was gained from relevant committees prior to commencement of the study, with additional ethical approval updates obtained during the study as required. Under the requirements of this approval ~~we~~the data was carefully managed ~~our data~~, which involved recording, organising and storing of all resources (including contact sheets, transcripts and field notes) to preserve its authenticity and protect those involved.

Data Collection

An 18-month longitudinal ethnographic study was conducted (Goulding 2005). Data were captured through (overt) participant observation, whereby a researcher accompanied informants (and companions) through their encounters with professionals. ~~We refer to~~ ~~t~~These encounters are referred to as ‘consultations’ to indicate a meeting with a professional that formed part of formal healthcare delivery. These consultations included meetings with clinicians, consultants, specialist nurses and other allied professionals. A researcher (from a team of 3) accompanied informants through a series of formal consultations to gain insight into the connectedness across the variety of encounters. Typical of ethnographic studies, multiple data collection methods were used (Elliott and Jankel-Elliott 2003). Observations were recorded and field notes taken. Observations were supplemented by scheduled depth interviews with informants. Corresponding interviews were conducted with the lead professional involved in the treatment of each person. These multiple data collection methods were arranged to capture immediate impressions of consultations, narrative reflections on encounters and subsequent choice behaviours from different perspectives.

Entrée was overt, through the clinical practice, with informants understanding the research goals and providing their informed consent. The study required the cooperation of primary and secondary care organisations and practitioners at various levels to smoothly follow patient pathways. The first phase entailed recruiting professionals within primary care practices and professionals in specialist diabetic, oncology and psychiatric units. Efforts to recruit organisations included telephone communications with practice managers and a small number of presentations to GPs. Thirteen consultants were recruited enabling us to track patients from primary care practices through referral to specialist units. In the second phase ~~we recruited~~ patients (N=24) were recruited from within the participating centres (breast cancer =3, all female, mean age=52 yrs.; prostate cancer = 9, all male, mean age= 67 yrs.; diabetes = 7, 4 male:3 female, mean age=55 yrs.; multiple conditions = 5, 2 male:3 female, mean age= 59.4 yrs.). During the study one person died and one withdrew.

The majority of consultations (55 out of 61) and all interviews (informants = 32, professionals = 13) were audio recorded. ~~We collected F~~field notes were collected for all 61 consultations. Where consultations were not recorded this was due to refusal on the part of the professional. Recordings were downloaded into recorder software and the audio files sent to a transcription service (via ftp). Verbatim transcriptions were returned.

Data Analysis

In terms of consultations (61), ~~we gathered~~ 951.60 minutes (15.86 hrs) of observations (mean consultation = 15.60 mins, s.d. = 8.10, range = 3-35 mins) were gathered. On average, the number of consultations observed per informant was 2.54 (s.d. = 1.77, range = 0-5). The difference in spread of consultation activity is reflected in the varying patient pathways (e.g., active surveillance versus swift intervention and periods of patient management in the case of Diabetes). Interviews with informants (32) lasted between 45-90 minutes, interviews with professionals (13) were by agreement shorter (due to work pressures) at 30 minutes.

Analysis was structured in two phases. In the first phase, ~~we undertook~~ an analysis of the interactions within the consultations was undertaken to provide insight into the triadic engagement structures. For the consultations, the data included patient, professional and companion input. ~~We thus coded the d~~Data was coded according to who was speaking, the type of consultation, condition category, and other aspects of the interaction between professional and patient/companion. ~~We use a~~A technique from conversation analysis was used, whereby share of the discussion is measured by percentage of the total word count per consultation (Allen and Guy 1974). This technique is useful in studying naturally occurring conversations with multiple inputs (often overlapping) to understand the relative share of conversations per actor (Elsbach and Krame 2016). First, ~~we directly observed~~ the composition of the consultations was directly observed, with emphasis on the existence of triads, the nature of those triads (the 'voices' involved being coded in terms of human or virtual). ~~We then measured t~~The share that each 'voice' had in the consultation was then measured based on the percentage of the total word count per consultation. Second, ~~we observed~~ the nature of the inputs was observed, developing a coding scheme based on the acquisition of space within the consultation (table 2). Again, ~~we measured~~ the share of each type of input (by associated voice) was measured using the percentage of total word count. The~~Our~~ analysis was supplemented by reference to field notes and clarifying insights from the interviews.

In the second phase, ~~we analysed~~ the nature of triadic engagement roles was analysed through (i) observing and identifying the nature of the exchanges within the consultations, (ii) checking ~~our~~ interpretations within the interviews, and, (iii) referring to ~~our~~ field notes. Following a "two-level scheme", specific 'emic' consumer understandings are nested in general 'etic' conceptual interests. A loose coding framework based on the theoretical constructs (figure 1) was used as an initial guide to organising the analysis (Attride-Stirling 2001). Following Corley and Gioia (2004), three researchers (including one of the authors) undertook open coding to identify the initial concepts within the consultation and interview transcripts on a line-by-line basis and organise these into a set of first order concepts (213 initial codes). This stage of coding was iterative, starting after the first few consultations and interviews (Mile and Huberman 1994). Axial coding was used to identify the relationships amongst first order concepts and arrange these into second-order themes. Finally, these themes were organised into aggregate dimensions. A fourth and fifth researcher were involved during these final two steps.

Following, Miles and Huberman (1994), ~~we utilise~~ triangulation was utilised to enhance the reliability and validity of ~~our~~the data and subsequent inferences. ~~We t~~Triangulation~~e~~ was at three levels. First,~~ at the level of~~ the data source ~~we~~ included (i) patients with acute and (multiple) chronic conditions, (ii) different stakeholder perspectives, such as healthcare professionals and companions, alongside the patient view, and, (iii) different (naturally occurring) sites of healthcare service delivery. Second, at the level of the researcher, a team of three researchers were initially involved in data collection to counteract researcher bias. Further, during data analysis, a further two researchers served to both challenge the initial coding phase and bring an ‘outside’ perspective as neither had been involved in the data collection. Third, ~~at the method level, we utilised~~ multiple data collection methods were utilised, that is, observation, interviews and supporting field notes. Careful recording of~~ our~~ consultations enabled ~~us to~~ revisiting of actual instances and preservation~~e~~ the authenticity of the data, whilst field notes provided pointers to any important influences on the event that would not have been recorded. These measures were essential for to ensure reliability in data collection. The interviews enabled us to gather feedback from the informants on their interpretation of each recorded event as a check against~~ our own~~ interpretations. Follow-up interviews allowed informants to reflect on previous instances and revisit their own interpretations. ~~Our~~This combination of quantitative and qualitative insights helps ~~us~~ in “protecting against bias” (Miles and Huberman 1994, page 253), ~~whereby we can~~enabling a countercheck ~~our~~of expectations and interpretations against actual counts of occurrences.

Findings

~~Our~~ The findings are mapped onto the two-layered framework of structures and roles that informs the~~our~~ conceptualisation of triadic engagement (figure 1).

1) Triadic engagement structures

~~We s~~Setting out to identify the voices present in the consultations, ~~adopting~~ the term ‘voice’ was adopted to indicate an influential source within the consultation, whether physically present or virtual. On this basis, ~~we established~~ the existence, extent and nature of triads within the consultations was established. Based on ~~our~~ observations of consultations, ~~we discerned~~ three triadic consultation structures were discerned: the human voice triad; virtual voice triad; networked voice triad.

a) The human voice triad: refers to the physical presence of a companion (e.g., a friend or family member) in the consultation that ~~we~~was observed contributing directly to discussions. ~~We~~It was observed that 62% of the consultations had some input from a physically present companion. The average share of the consultation (by percentage word count) for professionals, patients and companions is shown table 1. ~~We found i~~Instances were found where the presence of a companion changed the dynamics of the interaction. For example, where companion input was 10% or more, there was a noticeable decline in professional input, with the average input from the professional at 53% of the encounter (compared to the general average of 67.7%), and higher than average levels of patient input.

Table 1: Share of consultation (based on percentage word count)

~~We~~ It was observed during the consultations that the companion was augmenting rather than displacing patient contributions. There were some encounters in which the companion played a larger role than the patient, not merely in terms of the relative share of the consultation but also in terms of the nature of the interaction. Whether the input is feedback or questions, the professional is responding to both individuals who bring different perspectives to the encounter. The role of the companion was often to listen carefully to the details, because the emotional vulnerability of patients with these conditions caused the patient to lose concentration and not hear all that needs to be heard. There was evidence from the interviews that having a companion present increased the likelihood that the critical substance of the consultation was retained following the encounter: *"It helped having my wife there because she could remember the answers" (PC-9.1.92).* This in turn was linked to effective information acquisition by the patient. Further, companions subsequently played a major role in the process of acquiring independent information: *"X, who uses the internet an awful lot, she was at it straight away" (PC-1.i.31).* Additionally, the companion can remember to ask questions that the patient might have forgotten or to clarify things that might have been discussed. Sharing information about the patient is another way that companions enhanced the level of understanding for both patient and professional. In both prostate cancer and diabetes, the patient's partner was often enlisted to manage the necessary dietary changes.

~~We~~ It was observed that the human voice triad was most common among prostate cancer patients, with female companions (in the majority of cases the partner) playing a proactive role in the encounters. Prostate cancer patients took the lowest share of the consultation of participants across all conditions (table 1), perhaps competing for space with active partners and the professional. It is evident from the interviews that the nature of prostate cancer means it impacts not only on the patient but to a high degree on their partner, providing a major motivation for active partner interaction in the encounter. This extended beyond the consultation to broader resource acquisition activities.

Companions took the greatest share of the consultation in multiple conditions (table 1), suggesting medical and social complexity arising from comorbidities. These companions were most active in asking questions, rather than providing feedback, and this may reflect the need to incorporate a new condition into the identity of the patient as well as managing new medications that could interact with others currently being administered. It was also notable, partly reflecting the older profile of patients with multiple conditions participating in the study, that the companions were often adult children rather than partners: *"Y, my daughter, she's been looking and last night she was telling me that there were lots of leaflets available free of charge"* (MC-3.i.33). They were commonly internet active and demonstrated a high level of internet use in seeking to assist the patient in coping with their conditions and handling encounters with health professionals.

By contrast, the companion was least active with diabetic patients, and there was only one consultation where the partner was present. All other diabetic consultations, in which the least amount of active questioning took place, included only the patient. Often the diabetic encounter is a review after an interval of at least six, possibly twelve months, in which the consultant is asking many questions to update the record and to manage any new developments. The extensive experience of diabetic patients with managing their condition, and in particular the time elapsed since diagnosis, reduces the vulnerability of patients, resulting in increasing independent capability to handle the consultation process.

b) The virtual voice triad: refers to the introduction of external resources to the discussion between patient and professional. During the observations it appeared that explicit reference to external resources within the consultation was limited. For example, where there was a discussion of information it usually related to official information produced by the healthcare provider. ~~We~~It was observed that 26% of consultations exhibited explicit reference to a virtual voice. The average percentage share of the consultation given to explicit mention of the virtual voice was 0.9%. It is apparent from the interviews that many patients and their companions were accessing content from external sources, most commonly via the internet, outwith the consultation in preparation for the consultation, and to verify verbal professional advice post-consultation. Yet, of the consultations observed, there were a minority in which patients directly brought-up references accessed from outside sources. Further, a minority of patients within the interview identified actively bringing information to consultations. A point that is acknowledged by both professionals and patients who framed such behaviour in terms of not wanting to ‘show-off’:

“I mean we don’t overdo it. as far as the diabetes thing was concerned I wanted to know what this HbA1c or whatever it is [was] … because … when I went for the HbA1c blood test and she started trying to explain it to me I said 'yeah, it's about isn't it ba-ba-bam?', 'oh, right, somebody's been doing their research' and I said 'yeah'." (DI-1.i.54)

These parallel interactions of many patients with virtual voices, including the sharing of lived experiences in online and offline communities, occur independently of the professional and the formal consultation but nevertheless inform patient expectations and behaviours. This virtual voice manifests in change in patient behaviour in the formal consultation where there is a divergence between professional advice and external sources. For example, disagreeing with the professional. As such, for the majority of the participants who had engaged with external resources, this resource acquisition was indirectly evident through the questions that they asked or the feedback they gave. For example, some of the diabetic patients who had lived with the condition for an extended period of time would regularly look at American websites to find out what the next new steps in the evolution of diabetes care might be. The way they would use the information was primarily as an upgrade to the knowledge they acquired over the period during which they had been diabetic. Their interest was typically focussed on the latest development in diabetes care, e.g., the newest type of insulin, blood tests for Hb1Ac. Their search patterns were highly focused with a clear understanding of what constituted credible external sources. The resources acquired frequently underpinned detailed technical discussions with professionals, for example, in the case of one patient regarding potassium deficiency and blood test results. Being comparatively 'expert patients', these participants engaged with their professionals with some degree of sophistication and confidence, as one of the participants expressed: *"the knowledge is there and with knowledge and understanding comes confidence*" (DI-8d.i.127).

By contrast, both breast and prostate cancer patients frequently expressed the view that at least some of the websites they had accessed independently were frightening, especially those that focused on mortality rates and life expectancy. Some nurse specialists across both conditions noted that some patients had written themselves off after looking for information on the internet and that a major challenge during the early stages of patients' experiences was to rebuild their confidence. In contrast, others had found facing worst case scenarios as helpful:

"she said 'I've looked at it all, I know how bad it can be, you know, anything better than that is brilliant, so, you know, if I'm not as bad as that, I'll see it as a good point' … I just thought … going on the Internet has … done you the world of good.' (Professional – BC-D.i.141)

Further, a recurring theme across breast and prostate cancer was a major drop off in official information provision in later consultations, leaving patients feeling uninformed about long-term health management. This, together with the reduced patient vulnerability and increased technical knowledge appeared to stimulate engagement with the virtual voice in the longer term management of conditions.

c) The networked voice triad: A major element of the companion role was the acquisition of information, especially in the early post-diagnosis phase when the patient is typically emotionally vulnerable. In the case of partners there is a recurring sense that the condition impacts indirectly on the partner as well as the patient, generating a strong interest in seeking to exercise control over the condition at a stage when the patient is not ready to begin such a process. What ~~we~~ was observed were companions reaching out for support to other sources, and then introducing this into the consultation either explicitly or, more often, implicitly. As this practice spreads, the voices present in the consultation room come to represent the networked voice. There is evidence of a strong cross-generational dimension to the involvement of companions in the acquisition of external resources with adult children playing an active searching role on behalf of their parents, reflecting both their occasional role as carers and their familiarity with using the internet: *'my initial reaction would be 'I need to know something, I'll look it up in a book' … I call it a generational difference. My daughter, Z, would look it up on the internet'* (Patient – BC-A.i.70). Whilst such involvement may not extend to direct participation in the consultation process, such as in the case of Diabetes, it can still act as a back-room advising function: 'I've… looked up websites for… when she says 'oh I'm on these tablets' … she's had two bad episodes of … very, chronic low salt, and … ended up looking like she'd had a stroke, but she hadn't, it was just the really low salt level. And so I looked up that on the Internet, because she couldn't understand what had happened to her.' (Family Member – DI-10.i.159)

The consequence of the implicit networked voice is that access to external resources and interactions with other patients may lie beyond the visibility and control of the service organisation with which the patient is undergoing treatment. As such activity occurs independently of the formal service 'script', patients can explore alternative service 'scripts'. It does not necessarily follow that patients reject the formal service 'script', rather they are free to extend their resource acquisition beyond the boundaries set down by the service organisation. The possible permutations of the networked voice within/outwith the consultation are potentially limitless and almost impossible to track as multiple virtual voices are presented into the consultation merged into a single entity.

The longitudinal nature of triadic engagement structures

~~We sought to understand further t~~The longitudinal nature of triadic structures was further understood by exploring patterns of inputs within consultations over the course of the patient experience, specifically, diagnosis, treatment and review. ~~We conceptualised t~~The observed inputs were conceptualised in terms of claiming space within the consultation to make a contribution to the discussion, of which there were 3 clear types:

- Offering Space: where the professional invites specific patient input, triggered by offering space for questions. The patient may accept this space and ask questions or offer feedback with varying degrees of assertiveness; or reject the offered space.
- Acquiring Space: the patient intervenes without being invited by the professional, either through a (i) direct challenge or contradiction to the professional or (ii) offering a personal perspective.
- Augmenting Space: the companion (i) asks questions or (ii) offers feedback within the consultation.

Table 2 summarises the share of the consultation by percentage word count for each of the identified input categories. Whilst offering and accepting space between the professional and patient is fairly consistent as consultations progress, ~~we~~ it was observed that whilst the patient acquiring space through challenge of the professional is uncommon and diminishes over time, acquiring space through personal perspective increases. However, ~~we do not~~it was not observed that the behaviour of the consultant significantly diminishes over time instead ~~we observe~~ changes were observed in the input of patients and their companions. Focusing on these respective inputs, there are marked differences in the companion input across different phases of the consultation. The companion is very active in augmenting the space at the early stages of diagnosis. It can be surmised that this is linked to the vulnerability of the patient in the early stages of their condition and associated reliance on support. ~~We see a~~A shared decline was noted in patients acquiring and companions augmenting space during treatment phases. Perhaps, this reflects the professional's technical knowledge status. Although, patients and companions both start to increase their share of space again during review, particularly in terms of giving feedback.

Table 2: Input categories as % of consultation word count

Further, ~~in the consultations we observed~~ the presence of the virtual voice was observed in the consultations, albeit decreasing, in terms of share of the consultation (diagnosis: 2.1%, treatment: 0.6%, review: 0.7%). Conversely, ~~we see~~there was a general trend in virtual voice access over time. ~~We~~It was observed, supported by the interviews, that familiarity with their condition and phase of the patient experience are key influences on a patient's engagement with external resources (i.e., access to a virtual voice). Access to external resources is not uniform during the patient experience. Not only does usage fluctuate over the patient experience, from pre-diagnosis through to long-term maintenance but both the patient and professional interviews highlight a number of trigger factors that encourage patient (or companions) to engage with external resources.

One of the clearest themes to come from the longitudinal study data was that patients did not consult external resources prior to diagnosis. This was common across both acute and chronic conditions. *"I haven't looked up anything. Until I get a diagnosis I haven't – I refuse, I've stopped myself"* (Patient – MC-1.i.39). This was attributed both to the difficulties associated with finding out about their symptoms, specifically the challenge arising from many conditions exhibiting common symptoms, and a genuine concern of 'frightening themselves'. In the initial phases of the patient experience pre and immediately post diagnosis, patient vulnerability has the effect not only of discouraging interaction with external resources but also limits ability to filter and identify resources that are relevant to their particular circumstances: *"As soon as I found out I did have the early stage prostate cancer it was probably about a week before I kicked into gear"* (PC-1.i.31). Until the patient has relevant background information relating to the particular manifestation of the condition, for example, specific type of the condition or identified therapy, informed and targeted engagement with external resources is inherently difficult. At this point the tensions between increasing awareness of options and the relevance of such information to the individual are acute. Although lacking the underlying disciplinary knowledge base of professionals, it is evident that patients who have lived with a condition for an extended period of time demonstrate clear ability to acquire, evaluate and assimilate resources relating to both lived experiences of other patients and specialist technical information. This generates a capability for patients to integrate the acquisition of information with the contribution of lived experiences to relevant forums:

"I'm on a range of tablets for high blood pressure, cholesterol and whatnot. I like to find out what they do and what side effects they have. Now, if you had a pack of tablets, you've got about 100 different things that you've got to watch out for. But I don't want to know them, I want to know the real things. That is when you get the benefit of looking [on the internet] … where people have actually had the experience or side effects with tablets." (DI-7d.1.128)

Post diagnosis behaviour is different with an upsurge in utilisation of particularly online resources. Rather than suggesting a uniformity of behaviour, there is a spectrum of behaviour. For patients with chronic conditions a trigger for engaging with external resources was changes in their condition, especially proposed changes in their treatment regime. For these patients managing the lived experience of the condition is a primary concern and they are commonly highly informed about their condition. Any change in treatment has a potentially significant impact on their lifestyle, encouraging active engagement. Further, it is evident from the patient interviews that engagement with external resources was related to the ease of accessing health professionals: *"You can get the answer straight away and you don't have to go to the GP …they said 'well you can see the doctor', but … I don't think they've really got time to discuss things with you"* (DI-7d.id.128). This fits with the idea that patients increasingly integrate formal and informal resources in managing their conditions. Some patient narratives suggested this was a negative trigger in that external resources were treated as a substitute in the absence of the preferred option of face-to-face engagement with professionals.

2) Engagement roles

The second layer of the ~~our~~ framework refers to the nature of triadic roles within the consultation and the potential for these to change over time. Within the context of the observed consultations~~ we observed~~, and supported by the interviews, ~~our~~ the starting point was to identify the flow of roles and whether these follow the pattern of transactional (more passive) through transitional to transformational (more active) suggested in the literature. In the second step ~~we~~it was further determined if the evolution of the observed roles could be mapped at three levels: enhancement; empowerment; emancipation. There was a clear, observable alignment between transactional-enhancement; transitional-empowerment; transformational-emancipation roles. Initially roles of the professional and patient were narrated as being complementary (in terms of enhancing roles). However, ~~we observed that~~ some patients and companions increasingly engaged in more independent roles over time (in terms of empowerment and emancipation roles).

a) Enhancement Roles

Patients, companions and professionals articulated interlinked roles focusing on the transaction of information exchange, which ~~we~~was distinguished as 'professional resignation' and 'good patient'. The healthcare professionals in this study widely acknowledge that patients, particularly younger patients, are making increasing use of online and social resources (e.g., reaching out to others), and actively using such resources in their interaction with professionals. Yet, professional responses to this shift were varied. A minority were unenthusiastic about such individual access and argued against assisting access, refusing to recommend online resources to patients. The majority perspective was that, whilst unenthusiastic about patient access to online resources, there was an inevitability about this evolving behaviour. As such, professionals (resignedly) 'ought' to seek to manage patient access by recommending what they considered as appropriate resources:

'… the use of internet is going to be increasing in the future, that perhaps we should direct them to access certain sites on a regular basis so that they don't go randomly on the internet and find information then assume that this is what their trouble is. And, you know, destroy their peace of mind.' (Professional – BC-F.i.155)

From the non-professional perspective, at the heart of being a responsible consumer, a 'good patient' to use the phrasing of ~~our~~ informants, was the idea of being ready for the consultation, of being able to use the health service effectively. Effectiveness refers both to deriving maximum personal benefit from the healthcare system and also by attempting to use the system efficiently to maximise the societal benefit delivered by the system. At the core of preparation was understanding of the broad parameters of the condition and the process of treatment and care, as well as being prepared for subsequent stages in the patient experience. This understanding was narrated as enhancing service outcomes for the individual either through exercising informed choice or in coming to terms with the condition implications:

'… when you have the interviews with them, you're trying to take a lot of information in and trying to memorise it and, at the same time, trying to think of questions to ask, but I felt that by reading up before and going through it with them, I was actually one step ahead of the game, you know, so I was more relaxed about it, so if they did mention something then I thought, oh yes, I've read that, and it was already logged and that, so, oh yeah, I've got a very positive attitude to it and I hope not in an obsessional way.' (Patient – PC-9.if.162)

There was tension between these two emerging roles. From patient and companion (and professional) narratives it was evident that integral to recommendations made by the professional on resources was the attempt to place boundaries on patient/companion resource searching. For example, implicitly, and in some cases explicitly, there were attempts to confine patients/companions to searching approved sites that fitted with the treatment regime adopted by that professional and hospital:

'… when I was diagnosed, the surgeon said to me that it wouldn't be a good idea to go on the internet, other than use the sites that they […] recommended. […] I mentioned [that I was using the internet] to one of the doctors there when I was going quite often […] and they, sort of, pulled a face and said well none of it's been proved. Yeah they were very, you know, dismissive of that' (Patient – BC-6d.i.125)

While from a professional perspective such efforts to guide patients and companions around the complexities of their condition and external resources were based on efforts to ensure that patients/companions did not access misleading or incorrect information, there was a perception from some patients and companions that such recommendation was concerned with retaining control of the consultation.

b) Empowerment Roles

There was close correspondence between patient, professional and companion accounts in terms of more collaborative empowerment roles: with the 'professional as a navigator' and the 'patient/companion as assistant' in healthcare management. The dominant narrative of the evolving professional role within the interviews was of the professional as navigator. Within this professionally driven redefinition of the professional role there was, however, a dichotomy between the professional role in chronic conditions where the navigator role dominated and in acute conditions where a more traditional directing role was retained. At the same time, developing beyond the 'good patient' was the notion of the informed patient/companion being able to assist the professional. Where the professional adopted the role of navigator there was recognition of the need, indeed expectation, for the patient/companion to contribute to the consultation through being informed. Professionals perceived being unable to perform their role effectively in the absence of informed patient/companion input. As one professional stated, *'One of the most dispiriting things is to have a patient in front of you who says 'oh just give me some tablets, doc, and sort it out' and that's complete disengagement with their own disease.'* (Professional – DI-A.i.144)

Framed in terms of facilitating the professional role in enhancing the efficiency and effectiveness of the service provision, there was a strong ethos of the health services being a public benefit good and that patients and companions 'owed' it to the professional to actively assist in the process of delivery by being informed participants. Patients, companions and professionals broadly agreed that informed patients/companions enhanced the consultation. Typically, such consultations were perceived as richer and more satisfying for all parties and contributed indirectly to enhanced outcomes. However, from the professional perspective this presupposed that the patient/companion was capable and competent in using resources and that the resources used by patients/companions reflected the prevailing professional discourse. Where such conditions were met, patient, companion and professional views converged around the negotiation of the consultation space. Specifically, contributing (professionally acceptable) input was perceived by patients/companions to facilitate a marked improvement in interactions in terms of greater professional respect for the patient/companion and acknowledgement of their competence in an active role. In turn this led to a co-construction of the consultation and mutual sharing of the consultation space:

'Rather than, the doctor will say 'oh take these tablets', I'll say 'well hang on a minute, let me find out, I don't want to be taking more tablets, I've got enough to take', you know what

I mean? … I think that the, by having that information, the doctor has a different attitude to me. Well let's say he doesn't treat me like an idiot!' (Patient – DI-7d.i.128)

In parallel, professionals perceived that, although potentially challenging, the quality of consultations was enhanced by increasing levels of patient/companion knowledge through access to specialist resources. Such sophistication, particularly in terms of the technical aspects of conditions and treatments was seen to elevate the level of the consultation, facilitate more advanced discussion and assist the outcome of the consultation: 'patients know a lot more than they used to! And whatever you're saying is likely to be cross-checked as well … And they do ask you specific questions and in details what exactly is the histology and sometimes they write it down and go back and check and read about it on the Internet, it's amazing, yeah.' (Professional – BC-F.i.155)

Underpinning the development of these roles, ~~we observed~~ 'testing and balancing' was observed as an assertive process of questioning professional technical judgement outside the consultation, but that does not necessarily lead to (or is intended to lead to) either change in service provision or rejection of the professional view. Rather it is a process of testing professional views against independent resources and of balancing these potentially competing perspectives. The process of testing and balancing represents the emergence of patients and companions starting to take a more independent view of their role in healthcare. Testing and balancing was articulated as a factor in increasing patient/companion confidence in professional judgement and underpins the building of durable patient-companion-professional relationships. The testing and balancing efforts of patients/companions did not represent a lack of confidence in individual professionals or the health system. Rather it was expressed as integral to being a responsible patient or companion and ensuring that service provision reflects patient desires rather than the professionals':

'I did with the Herceptin when they said I didn't need it – just to make sure that what they had told me, which was that […] it's a HR plus or a minus and I think I'd got the minus and he said 'so you don't need Herceptin' but I went and checked that just in case. Mainly because I know it's the most expensive drug going and I thought 'if you're just saying that to cut down the costs – I don't want to be in your seat when I find that out'. But it just confirmed what they'd told which – that's fair enough.' (Patient –BC- 5.if.173)

c) Emancipation Roles

For some ~~of our~~ patients and companions ~~we observed~~there was a further shift to a more explicit independent role of the 'patient challenger'. This manifested in open challenging of the professional and holding them to account. In parallel, ~~we also observed~~ a reconciliation between patients, companions and professionals was also observed in terms of their respective input into healthcare. The corollary of patients and companions actively contributing to the service process is holding service providers to account for the standards of service provision. The responsible service user, the active patient/companion, will utilise available resources to exercise choice and challenge service providers, thereby improving standards of service provision and enhancing efficiency. Participants in the longitudinal study articulated sophisticated understanding of the issues around holding professionals to account. There were circumstances where the exercising of responsibility led to active challenging of professional advice on the basis of information acquired independently and a changing of service provision:

‘… one of the antidepressants they were going to prescribe, after the first episode, I looked it up and it said it brings your sodium levels down and I went to my mum, ‘just mention that’ and so she took it to the doctors, the information, and he went ‘oh, right, well, we’ll try another one then’ (Family Member – DI-10.i.159)

Adopting this role did not necessarily result in a diminution of trust in professionals, erosion of patient-professional relationships, or rejection of professional expertise. Instead, seeking other resources and challenging the professional was linked to recognition of the bounds to professional knowledge. Yet, what is shifting is the basis of trust. While a strong relational trust element continues for certain groups of ‘convinced’ patients, there is evidence of trust being anchored in informed judgement. This trust is based on information relating to evidence of the performance of individual professionals or hospitals and the efficacy of alternative treatments. Although in the majority of reported instances such information was acquired independently, there were instances of professionals directly providing performance data. In such cases, the quality of the patient-professional relationship appears to be critical in shaping patient acceptance of the veracity of such information:

‘he was very candid about success and failure. I didn’t feel at any point he was bluffing me and he just explained the upsides and downsides, explained that the statistics he was giving me were not general statistics, they were his own statistics of success and failure.’ (Patient – PC-9.i.92)

It is evident that satisfaction is maintained where professionals respond to patient and companion challenges and adapt service provision if the challenge is demonstrably substantive but is lost where there is an out-of-hand dismissal. Developing effective patient-companion-professional relationships is dependent on active professional engagement with patient/companion generated resources. It is reasonable to suggest that far from relationships being eroded by the emancipated patient/companion, relationships can be strengthened by appropriate handling of patient/companion-initiated information provision. Indeed, access to external resources together with high profile media portrayal of divergent professional opinions regarding conditions and treatment (e.g., MMR) has increased patient/companion awareness of the possibility of alternative approaches to the management of conditions. ~~We observed~~ There was evidence of a high level of awareness of the limits on, and potential bias in, professional knowledge and expertise. Most commonly articulated in respect of primary care professionals, there is an appreciation that even the knowledge of secondary care professionals is bounded. Equally there is recognition that professionals cannot be fully knowledgeable about the lived experiences of patients which, particularly in chronic conditions, are central to the effectiveness of treatments. As such, the patient/companion has a responsibility to contribute to the consultation regarding their lived experiences and/or treatment options:

‘It’s made me more open to the consultant, because I can actually discuss things with them, plus you can also share new items, you know, sometimes doctors don’t have all the time to see these new options that are out and they turn round ‘I’ve never heard of that’, ‘oh it says this about it’, and you can actually quote who the doctor was that’s done the research or has actually developed this system and they turn round and say ‘oh, leave it with me, ‘I'll have a look’, and then they can come back with their thoughts on it.’ (Patient – DI-4.i.116)

Professionals also recognise that their knowledge is bounded particularly in respect of the sources utilised by patients/companions. As such, awareness of the sources used by patients/companions is a significant aspect of the maintenance of their professional expertise, particularly in terms of engaging effectively with patients/companions:

‘So it gives me an indication of what the general perception is out there and increasingly there’s more websites on laparoscopic radical prostatectomy, there’s more websites on prostate cancer, so I can see if people around the country are putting this – and […] – it gives me a flavour of the country’s attitude to it really.’ (Professional – PC-B.i.68)

Discussion

~~We~~ This study contributes to an understanding of how to move beyond the traditional dyad of consultations and recognise that engagement in healthcare is increasingly triadic. Our first contribution is to offer a framework for triadic engagement based on the fundamental premise that triadic engagement is an evolving process. Our framework positions this process as composed of two interlinked layers: triadic engagement structures and triadic engagement roles that are adopted by three main categories of actors; consultants, patients and third voices in people-centred healthcare (Danaher and Gallan 2016).

Triadic engagement structures recognise that the inclusion of a third voice in the consultation, whether physical or virtual, changes the underlying nature of the discussion. In line with recent studies (e.g., Keeling ~~et al.~~*et al.* 2015), this study~~we~~ identifies~~y~~ and distinguishes between the human voice, the virtual voice and the networked voice in the structure of triadic consultations. The human voice represents patient-professional-companion engagement patterns, where health is understood from the interrelations between these three voices. The relative balance of the consultation is divided between ‘Offering Space’, ‘Acquiring Space’, and ‘Augmenting Space’. Beyond this, the virtual voice represents patient-professional-virtual voice engagement patterns. The networked voice represents patient-professional-companion-virtual voice. As such, estimates of the occurrence of triadic consultations may be much more than originally estimated (at up to 60%) as they do not count the virtual or networked voice.

Building on recent theorising regarding the social component of engagement (Hollebeek ~~et al.~~*et al.* 2016), there is a need to look beyond the confines of the consulting room, to include the parallel interaction of patients with virtual voice(s). This includes the sharing of lived experiences with the wider network and exploring the ecosystem within which value creation takes place (van Oerle ~~et al.~~*et al.* 2016, Vargo and Lusch 2016). These instances occur independently of the professional and the formal consultation but nevertheless inform patient expectations and behaviours. Understanding how these engagement patterns impact on health management, ~~we must refocus our~~the prevailing perspective should be refocused by questioning what constitutes acceptable knowledge and expertise, how and whose voice is being heard and who is driving the conversation (Swinglehurst ~~*et al.*~~*et al.* 2016).

The notion of triadic engagement roles acknowledges a need to reframe the parameters of the healthcare encounter. Professionals, patients and companions recount an increasing sophistication in role renegotiation within the consultation. This sheds light on the possible complexity and richness of the individual resources (Harmeling ~~et al.~~*et al.* 2017) that patients and third voices can add to the consultation, distinct from the consultant. Patients have evolved beyond bringing printouts into the consultation, they control the knowledge they have acquired carefully, dealing with it in a considered manner in light of professional behaviours. This hidden process of reflection, consideration and formation of opinions outside of the consultation, which patients (or companions) do not necessarily admit to professionals, occurs in parallel with engagement with professionals and is critical in shaping expectations and demands (Dowell ~~et al.~~*et al.* 2013).

~~We identify t~~The emergent roles within the broader classification of engagement, empowerment and emancipation (c.f., Botin and Nøhr 2016) are identified. ~~We observe that t~~Through enhancement roles there are tentative steps towards promotion of the responsible consumer and increasing expectations on patients (and their companions) to utilise resources in making decisions regarding their treatment. Through empowerment roles patients, companions and professionals perceive they achieve an enhanced consultation alongside other sub-processes, such as learning, sharing and socializing (Beirão ~~et al.~~*et al.* 2017). Typically, such consultations are characterised as richer and more satisfying for all parties, contributing indirectly to enhanced outcomes. ~~We~~ On reflection ~~that~~ this presupposes patient and third voice capability and competencies (Graffigna ~~et al.~~*et al.* 2016). This aligns with the role of the responsible healthcare user who actively challenges the service delivery to enhance its efficiency and effectiveness. This does not seem to affect trust perceptions. Through emancipation roles, there is informed trust in professionals rather than a diminution of trust or automatically eroded patient-professional relationships. What, however, is shifting is the basis of trust. While a strong relational trust element continues to exist for certain groups of patients, there is also strong evidence of trust being anchored in informed judgement. The quality of triadic engagement appears to be critical in shaping trust.

Figure 2: Extended framework for understanding triadic engagement

Contributing to the debate over the roles and structures underpinning patient engagement (Hardyman ~~et al.~~*et al.* 2015) and building on recent propositions regarding the dynamic nature of engagement (Venkatesan 2017), ~~our~~the second contribution is to map the evolving triadic engagement roles and engagement structures over time (figure 2). This is particularly relevant in the case of healthcare services that treat prolonged and complex conditions (Spanjol ~~et al.~~*et al.* 2015, McColl-Kennedy ~~et al.~~*et al.* 2017). Considering the transformational power of engagement with a condition over time, ~~we observe~~ a concomitant change in the nature of the consultation over time was observed. The significant time events identified in this study are diagnosis, treatment and review. Along this timeline, ~~we observe~~ an evolution in triadic engagement roles was observed from transactional roles that enhance consultations through to more transformational roles that free the patient and/or companion to take more share of the consultation, and also more responsibility for healthcare outwith the consultation in terms of self-management and self-educating.

However, ~~we do not observe~~ a total rebalancing to a shared leadership pattern was not observed for all of those involved in this study (c.f., Carman ~~et al.~~*et al.* 2013). Instead, ~~we observe~~ a more general move towards conversations rather than consultations was observed, with the patient openly challenging the professional, taking more of a lead in the management of their healthcare, and directly bringing in more of their own perspective on living with a condition. There are in parallel observable shifts in the triadic engagement structures over time, with a distinct split in the engagement of explicit versus virtual/networked voices over time. First, ~~we observe~~ as a general pattern, ~~that~~ patients and companions are more active in the diagnosis and review stages, being less active in the treatment stage. This further nuances recent findings on the changing role of healthcare customers in co-creating value with health service providers (McColl-Kennedy ~~et al.~~*et al.* 2017).

Second, engagement with virtual/networked voices increased steadily over time, although not explicitly acknowledged in the consultations. As such, despite an observable reduction in active patients/companions at the treatment stage, there is increasing activity in engagement with virtual sources in terms of checking on treatments. This adds further insight to ~~our~~ understanding of the social component of engagement (Hollebeek ~~et al.~~*et al.* 2016). Third, providing understanding into the transition from a passive to a more active role for patients (Smith ~~et al.~~*et al.* 2015), ~~we~~it was observed that the development of engagement structures is one step behind the developing engagement roles. Such that, the professional continues to dominate the structure, whilst engagement roles are more advanced. This may be influenced by the stage of the condition and/or by the need for engagement roles to become embedded before significant change in the overall structure is possible.

~~Our~~A third contribution is to identify the heterogeneity in the observed patterns across disorders. In terms of triadic engagement structures, ~~we observe~~ differences in patient and companion contributions were observed during consultations (Spanjol ~~et al.~~*et al.* 2015). However, this is not reflective of the acute versus chronic difference that ~~we~~ might have been expected, rather there are contrasts within these groups. For example, in the acute conditions, patients with Breast Cancer tend to take a higher share of the consultation, whereas those with Prostate Cancer the least share, with a concomitant decrease/increase in the professional's share of the consultation. Furthermore, with regards to chronic conditions, in the Diabetes condition the companion, if present, makes the least contribution. Whereas, in the Multiple condition category, companions make the most contributions overall. It can be surmised that these differences are most likely due to the nature of the condition and how it impacts on family life versus the individual. However, there were acute versus chronic conditions with regards to the virtual/networked voice triads. Those in the chronic conditions are more likely to engage in such triads over time. Further, in terms of the evolving triadic engagement roles there is a tendency in those with chronic conditions to develop through to emancipation roles, with those in acute conditions tending to reach empowerment roles. These trends are most likely due to the need for more self-management over time, as well as the longer term impact on everyday life conditions for those with chronic conditions.

Practical implications

Responding to calls for engagement frameworks that have actionable propositions (Venkatesan 2017), the implications of ~~our~~the developed framework for policy and practice are three-fold. First, recognition of the existence of a parallel set of virtual informational and service activities in which individuals engage, and, hence, identifying opportunities where self-service activities can be integrated into the conventional face-to-face encounter (c.f., van Oerle ~~et al.~~*et al.* 2016). For example, encouraging patients to research their condition before a consultation within structured tasks would encourage more explicit discussion of online material or highlight core misunderstandings.

Second, and building on the first point, to move perspectives on the consultation process from a dyadic patient-professional focus to a broader triadic or network orientation around the patient, their companions (relatives, friends or carers) and the professional. Like companies in the private sector, healthcare organizations could facilitate online forums in which medical professionals engage with patients and their carers to extend interaction and co-create value (van Oerle ~~et al.~~*et al.* 2016). It has been shown that there is an increasing willingness of healthcare professionals that are open to this (Keeling ~~et al.~~*et al.* 2015). The effective integration of such third voices is vital to achieving increasingly effective healthcare consultations and outcomes. The significance of triadic engagement is that the inclusion of third voices is not confined to the face-to-face interaction within the conventional encounter, but also encompasses inclusion in support acquisition parallel to but separate from this encounter. These virtual third voice contributors represent a critical resource in assisting patients, particularly vulnerable groups, to engage with support resources and thus become active participants in the service delivery process.

Third, there is a need to facilitate the tailoring of support resources to meet expectations of patients and companions and the development of guides for professionals and third parties to inform support seeking practices. This would enhance the consultation process through shaping expectations, bringing a common approach to support acquisition, and integrating third voices more effectively into the consultation process. It would also facilitate the transformation of roles from enhancement through to emancipation (Botin and Nøhr 2016).

Future Research

There is immediate scope for further research in four areas. First, given evidence of companion(s) involvement in supporting patient resource acquisition and usage, both within and beyond the conventional encounter, it is important to understand how such third voices, as opposed to patients, engage with and evaluate supporting (offline/online) resources. ~~We have~~This study has identified a framework; future research can map patterns of third voice use of support resources, and identify the degree of commonality or divergence of their behaviours from that of patients. Such research would fit with prevailing concerns around the personalisation of healthcare delivery and patient safety issues.

Second, previous research points to the influence of patient demographics (i.e., age, gender and education) on level of patient engagement (Davis ~~et al.~~*et al.* 2007). There is evidence in ~~our~~this study that companions also differ in their contributions dependant on gender, as well as evidence of patient and companions potentially competing for space. Further research should therefore identify not just individual demographics of patient and/or companion but how combinations of these demographics impact on engagement across consultations.

Third, this study~~we~~ demonstrates the presence of a networked voice within the consultation. Given that this trend is likely to continue (Jiang and Street 2017, Peterson ~~et al.~~*et al.* 2017), it is appropriate to investigate how integration of the networked voice is likely to take shape over the next decade, and the implications for impact on consultations (especially where these become virtual in nature). Moreover, extending recent research by Van Oerle ~~et al.~~*et al.* (2016), a worthwhile future research avenue would be to study the development of engagement over time across different types of online healthcare communities as sources of patient support.

Fourth, and building on previous points, there is a ~~we~~ need to establish how patients, professionals and companions learn from their encounters within and across consultations to build their capabilities in negotiating and managing healthcare. This should take account of interactions at the structural (macro), formal consultations (meso) and informal network (micro) levels (Botin ~~et al.~~*et al.* 2015). Specifically, a focus on how capabilities can facilitate or hinder the development of a shared leadership model is necessary with implications for person-centred care policy and the development of educational tools to support such a model.

True triadic engagement (and, thinking into the future, networked engagement) is no doubt difficult to achieve, relying on policy, physical/organisational infrastructure and processes aligning to facilitate transparency, effective communications, education, and shared decision making (Sarrami-Foroushani ~~*et al.*~~*et al.* 2014). However, it is equally no doubt worth the investment, with the potential to improve patient satisfaction, treatment outcomes and overall quality of life.

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	Professional	Patient	Companion	Length (mins)
Average (word count)	1613	667	104	15
Minimum	159	38	0	3
Maximum	8021	2375	503	35
Share of Consultation (% of word count)	67.7%	28.0%	4.4%	
Breast cancer	55.4%	39.1%	5.4%	11 (ave.)
Prostate Cancer	70.6%	25.4%	3.9%	18 (ave.)
Diabetes	63.8%	34.1%	2.0%	19 (ave.)
Multiple Conditions	66.0%	26.7%	7.3%	12 (ave.)

Table 1: Share of consultation (based on percentage word count)

	Professional	**Patient**			**Companion**	
	Offering Space	Accepting Space	Acquiring Space through challenge	Acquiring Space through personal perspective	Augmenting Space through questions	Augmenting Space through feedback
Overall (n=57)	98.25 (56)	96.49 (55)	5.26 (3)	38.84 (21)	42.11 (24)	54.39 (31)
Diagnosis (n=10)	100 (10)	100 (10)	10 (1)	40 (4)	60 (6)	70 (7)
Treatment (n=24)	100 (24)	95.83 (23)	0 (0)	16.67 (4)	37.5 (9)	45.83 (11)
Review (n=23)	95.65 (22)	95.65 (22)	8.70 (2)	56.52 (13)	39.13 (9)	56.52 (13)

Table 2: Input categories as % of consultation word count

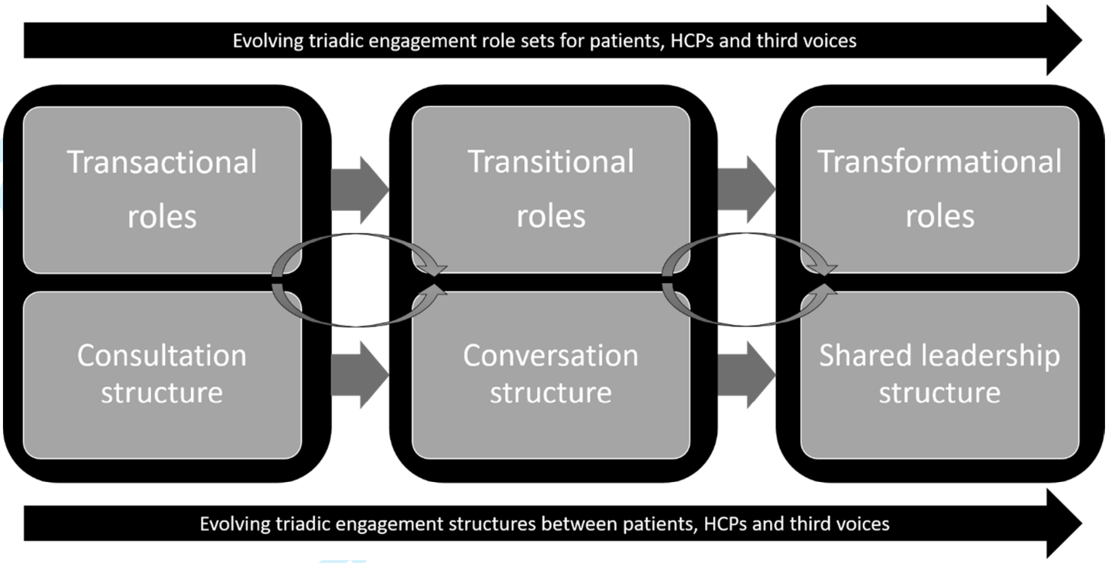

Figure 1: A Framework for Triadic Engagement

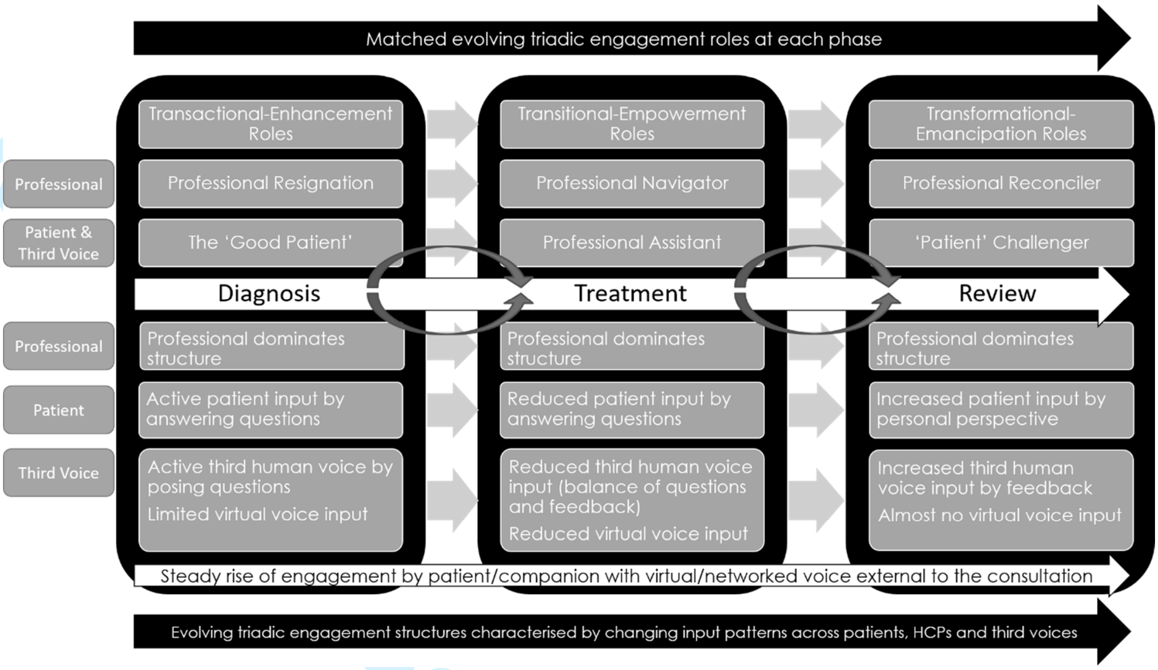

Figure 2: Extended framework for understanding triadic engagement