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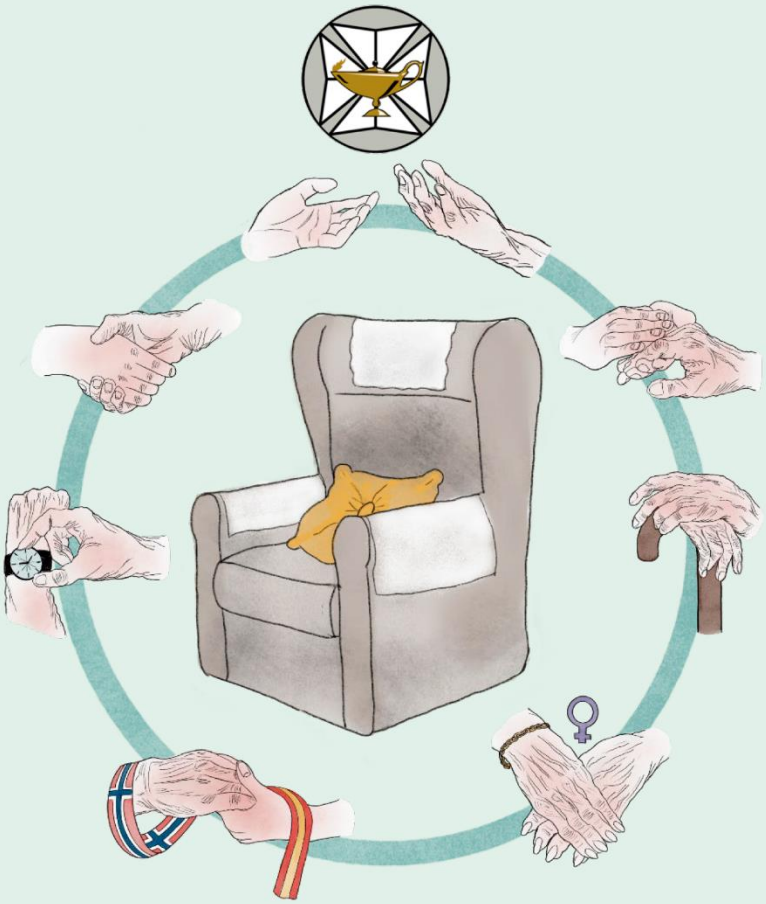
Programa de Doctorado en Lenguas y Culturas

TESIS DOCTORAL CON MENCIÓN INTERNACIONAL

Colaboración terapéutica en la atención comunitaria a personas mayores. Una aproximación desde el análisis crítico del discurso

Therapeutic collaboration in community care for older people. An approach through critical discourse analysis



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28 de abril de 2023

UNIVERSIDAD D CÓRDOBA

TITULO: *Colaboración terapéutica en la atención comunitaria a personas mayores. Una aproximación desde el análisis crítico del discurso*

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DOCTORANDA/O

Pablo Martínez Angulo

TÍTULO DE LA TESIS:

Colaboración terapéutica en la atención comunitaria a personas mayores: Una aproximación desde el análisis crítico del discurso

INFORME RAZONADO DE LAS/LOS DIRECTORAS/ES DE LA TESIS
(se hará mención a la evolución y desarrollo de la tesis, así como a trabajos y publicaciones derivados de la misma)

El desarrollo del proyecto investigador y docente del doctorando se ha caracterizado, en todo momento, por la enorme dedicación e interés, así como por la eficacia en la consecución de los objetivos propuestos.

En el desarrollo del proyecto investigador, el doctorando ha puesto en práctica numerosas habilidades y procedimientos investigadores, destacando, entre ellos, el análisis crítico del discurso, que constituye el núcleo metodológico de su propuesta. Además, la elaboración de una Revisión Sistemática – en proceso de decisión final por parte del editor de la revista BMJ Open-, junto con una Meta-síntesis de estudios cualitativos primarios le ha permitido desarrollar, también, habilidades para el análisis, gestión y síntesis de evidencia científica.

Así, al finalizar dicho proceso, el doctorando ha producido cuatro artículos, uno de los cuales ya ha sido publicado y otro aceptado, encontrándose dos más en proceso de decisión final para publicación por parte de diferentes revistas.

Más concretamente, y en cuanto a los resultados de la investigación ya existentes, el doctorando ha publicado un artículo en la revista Geriatric Nursing: Martínez-Angulo P, Muñoz-Mora M, Rich-Ruiz M, Ventura-Puertos PE, Cantón-Habas V, López-Quero S. "With your age, what do you expect?": Ageism and healthcare of older adults in Spain. Geriatr Nurs. 2023 Mar 13;51:84-94. doi: 10.1016/j.gerinurse.2023.02.020.
Por otro lado, le ha sido aceptado para publicación otro artículo en la revista Healthcare: Analysing Power Relations among Norwegian older patients and Spanish migrant nurses in Home Nursing Care: A Critical Discourse Analysis approach from a Transcultural perspective.

También es necesario señalar, que el doctorando ha realizado una estancia para mención internacional en la Universidad de Oslo (Noruega), desde el 15 agosto 2022 al 13 octubre 2022; y desde el 16 enero 2023 al 14 febrero 2023.

Respecto a su proyecto docente, el doctorando ha realizado diferentes y numerosos cursos formativos que han aportado solidez a su trabajo investigador, destacando sobre todo los realizados mediante el Centre of Discourse Studies de Barcelona, cuyo director, Teun van Dijk, es también el autor de referencia que el doctorando ha tomado para la realización de sus estudios críticos del discurso.
Además, ha tenido oportunidad de desarrollar sus habilidades pedagógicas durante su contrato como Personal Investigador en Formación asociado al Plan de Plurilinguismo de la Universidad de Córdoba, dentro del Departamento de Enfermería, Farmacología y Fisioterapia. Entre dicha docencia impartida tanto en español como en inglés, se encuentra, además, la tutorización de numerosos TFGs, lo que ha contribuido, sin duda, a la mejora su capacidad para el planteamiento de trabajos de síntesis de conocimiento y de generación de conocimiento nuevo.

De este modo, y puesto que todos los objetivos han sido alcanzados, y se cuenta con indicios de calidad suficientes, se autoriza la presentación de la tesis doctoral.

Por todo ello, se autoriza la presentación de la tesis doctoral.

Córdoba, a 27 de abril de 2023

Las/los directoras/es

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Las personas que me conozcan saben que, para mí, expresarme en pocas palabras es un reto al que el camino profesional que he elegido emprender —e intento cada día de mi vida elegir, a pesar de tantas adversidades— le parece pertinente plantearme repetidas veces. Esta es una de esas veces.

Comenzar las líneas de un espacio tan accesorio como primordial mencionando a mis directores de tesis es algo que, por descontado, siento que debe ir primero: como la primera piedra que dará paso a todo un edificio personal.

A mi director de tesis, el Prof. Dr. D. Salvador López Quero. Contigo comienza ahora mi primera dificultad ante el reto que he mencionado previamente. Y es que he perdido la cuenta de las veces en que te habré dado las gracias. Cuando más necesitaba a alguien que me mostrara alguna puerta que pudiera abrir para cruzar hacia la morada de los Estudios de Doctorado, tú me diste las llaves y me acogiste en tu casa: la Plaza del Cardenal Salazar. Y es justo en este preciso instante que me cercioro de que yo pertenezco, en cierta forma, también a esa casa. Las casualidades de la vida me han llevado hasta las letras, al corazón de la Lengua y la Cultura; de donde yo siempre he sido, de la ensenada del discurso y la rosa íntima de la palabra. Me has acogido y brindado la oportunidad de que me sienta como pez en el agua, y me has hecho confirmar un mantra que siempre he tenido en mi mente: la enfermería es una ciencia maravillosa, tan humanística como integral. Mi disciplina rezuma discurso por los cuatro costados, a la par que Filosofía y también Letras. A tu generosidad excelsa; tu presencia cuando la he necesitado, y a tu esfuerzo y buenas palabras, siempre.

A mi director de tesis, el Prof. Dr. D. Manuel Rich Ruiz. Contigo llega la segunda vez en que se me ha difícil dedicar tan solo unas líneas. Y qué más podría decir, o cómo decirlo. Todavía recuerdo, como si el reloj de la vida no contara horas sino momentos, mi primer acercamiento al apasionante viaje que es la investigación y la docencia con mi trabajo final de grado, donde confiaste en mí desde tan temprano, y de tu mano dejaste que en mitad de un aula llena de estudiantes de enfermería diera mis primeros aspavientos por estos lares, cual recién nacido. Los años que han pasado me han servido para admirarte desde todos tus recovecos como profesor, persona y más tarde, como compañero. No importa la circunstancia o el contexto: tu respuesta siempre fue recibirme, escucharme y cuidarme. Un sí incondicional a todo cuanto se nos pusiera por delante. Jamás he percibido nada de tu persona, por ínfimo que sea, que no se corresponda con diligencia, compromiso, respeto, entrega, saber estar, dedicación, vocación, cariño, humildad, cercanía y, sobre todo, humanidad. Serás el espejo al que quiera mirar y verme reflejado, en estos días que nos quedan.

A todo el departamento de Enfermería, Farmacología y Fisioterapia, y en especial al área de Enfermería. Sería un despropósito dejar atrás algún nombre de las personas compañeras de esos pasillos que tanto me hacen sentir como en casa, por lo que imprimiré vuestros nombres en estas líneas que os dedico. Desde el primer momento me habéis acogido y tratado con cercanía, y eso es una suerte con la que no todo el mundo cuenta. Soy consciente de ello.

De la misma forma en que sería un despropósito dejarme atrás a alguna persona de esos pasillos del área de Enfermería, también lo sería no nombrar de ese mismo área a quienes han sido, siguen siendo, y espero que durante mucho tiempo así sea, mis compañeras y compañeros que abandonan esa categoría de

partida para convertirse en amigos y amigas. Gracias a Rocío, Vanesa, Jose, Rafa y Pilar, por vuestro aliento, cercanía, complicidad; por esos momentos de compañerismo, de risas por no llorar. Gracias por darme la oportunidad de tendernos la mano unos a otros cuando caemos al más profundo de los avernos por un sistema que en ocasiones nos aprieta demasiado, o cuando simplemente tenemos un día de esos raros. Gracias por cualquier conversación exprés bajo el marco de la puerta de algún aula, o tomar un café en algún despacho que no es más que una excusa para encontrar un momento juntos y evadirnos de la apisonadora que es el día a día.

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A todas las personas participantes de esta presente tesis, desde las personas mayores hasta el personal de enfermería involucrado. A todo el equipo que ha aportado de alguna manera u otra su granito de arena en sacar estos estudios adelante.

A la Universidad de Oslo, y su facultad de medicina, por acogerme durante la realización de mi estancia para la obtención de la mención internacional para mi tesis. Gracias por decir sí continuamente a un chico desconocido que llegaba

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No obstante, esta tinta que escribe tiene muchos más nombres que mencionar más allá del entorno académico-laboral del día a día.

A mi madre, mi padre y mi hermana María. Gracias por ser siempre un apoyo incondicional, ya sea a miles de kilómetros de distancia en frías tierras noruegas o a centímetros de distancia. Gracias por transmitirme cada día intensamente principios como el trabajo, el sacrificio, la bondad, la honradez, la disciplina y, sobre todo, la humanidad. Agradeceré siempre que pongáis por delante a mi disposición todo lo que habéis tenido, tenéis y tendréis. Vuestro desinterés cuando hacéis eso es tan insultante como tierno, algo que me hace mantener los pies en el suelo y darme cuenta de lo mucho que aún tengo que aprender en la vida. Mamá, siempre te has esforzado en entenderme, comprenderme y ver las cosas con mis ojos para darme el amor que toda una madre pueda dar y vaciarse. Papá, siempre has tratado de transmitirme unos valores personales que se fundamenten en el respeto, la pasión por lo que uno hace y la dignidad, y que cada vez que me levanto por la mañana, intento vestirme con ellos y llevarlos por bandera. María, siempre has estado cuando lo he necesitado y tu sensibilidad y humanidad me ayuda a ver de dónde vengo y hacia dónde debo ir. Gracias a mi familia.

A Jessica, una persona tan especial como peculiar, con tantas capas de color que es difícil quedarse con uno solo. Eres la persona más fuerte que he conocido en mi vida, con un carácter igualmente fuerte y difícil, señal de que eres capaz de

sobreponerte ante cualquier adversidad por abrumadora que sea: cuando no hay más que una oscuridad que engulle tu cintura, chasqueas los dedos y surge la luz. Puedes con todo y, a la vez, con nada. Eres una combinación perfecta de un caos equilibrado cuya balanza fulgura con intensidad pasmosa. No existe ni un ápice de ti que no admire: tus principios férreos, tu dignidad infranqueable, tu calidad humana, tu brillo, tu compromiso brutal con lo que haces, tu capacidad de trabajo y entrega inmensa en todos los planos de tu existencia. Esta tesis te ha castigado a ti especialmente y más que a nadie, a nosotros. Y cuando has tenido mil razones para bajar los brazos, has encontrado mil y una para mantenerlos levantados con amor. Ojalá todas las horas que le he dedicado a la pantalla valieran la mitad de lo que tú, y mi madre, mi padre y mi hermana valéis. Prometo que recuperaremos el tiempo invertido en este libro.

A Ainara y David, por ser hogar en tierras baldías del gélido norte. Por ser inspiración y espolearme intelectualmente. Por ser una proyección vívida de la pasión por la Ciencia, de la necesidad de aprender y mejorar cada día. Cuando me sentía apagado o algo más pequeño, escucharos simplemente hablar o veros, me hacía recargar de energía para continuar con mi periplo. Gracias por acogerme, brindarme vuestra hospitalidad, generosidad y calidez cuando hacía más frío.

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A todas las personas que han formado parte de mi vida y han contribuido, de forma consciente o no, a moldearme a mí y por ende, a esta tesis.

Y, por último, me gustaría romper la tercera pared de este largometraje, y darme las gracias a mí. Por la pasión con la que intento impregnar mis clases, mi investigación y mi existencia. Por mi capacidad de sacrificio, por intentar siempre aprender, y desaprender, cada día. Por deconstruirme continuamente, y tratar de entender las circunstancias de la persona que tenga en frente. Por vivir con entusiasmo, hablar escribiendo y soñar despierto. Por vaciarme y dejar un pedacito de mí en lo que estás a punto de leer.

Por seguir adelante, y levantarme ciento una veces cuando ya me había caído cien, pues, como decía Sylvia Plath, *no es noche esta de ahogarse: luna llena, reacio río bajo luz suave*.

“Abre los ojos, piensa, entiende cómo es la naturaleza alrededor, eso que compartes con todo lo que te rodea. No vale escaparse, no vale ya el retiro en la montaña, ni la megalomanía de lanzarse al monte a buscar a dios o a pelearse con el demonio, todo está dentro de uno —el amigo y el enemigo— y en todo lo que te rodea: no eres un héroe, eres un emperador y has de estar en escena en todo momento, para que salir a saludar se convierta en un acto tan profundo como salir a despedirse, y viceversa. El pensador-emperador en escena”.

Prólogo de ***Meditaciones***. **Marco Aurelio** (121-180 d. C.).

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Para la realización de la presente Tesis Doctoral el autor ha tenido en cuenta a lo largo de su redacción las *Orientaciones para el empleo de un lenguaje inclusivo en cuanto al género en español* de las Naciones Unidas.

Índice de Abreviaturas

ACD	Análisis Crítico del Discurso
ECD	Estudios Críticos del Discurso
AD	Análisis del Discurso
LC	Lingüística Crítica
LFS	Lingüística Funcional Sistémica
LCg	Lingüística Cognitiva
AHD	Aproximación Histórico-Discursiva
MCP	Memoria a Corto Plazo
MLP	Memoria a Largo Plazo
ME	Memoria Episódica
ACECD	Aproximación Cultural a los Estudios Críticos del Discurso
EC	Estudios Culturales
PC	Pragmática Cognitiva
AP	Argumento Pragmático
TDC	Toma de Decisiones Compartida
OG-TD	Objetivo General de la Tesis Doctoral
OE-TD	Objetivos Específicos de la Tesis Doctoral
O-P1	Objetivos de la Producción 1
APE	Autopercepción del Proceso de Envejecimiento
O-P2	Objetivos de la Producción 2
EP	Expresión de Preferencias
PAC	Participación Activa en los Cuidados
O-P3	Objetivos de la Producción 3
EAP	Escucha Activa de Preferencias
O-P4	Objetivos de la Producción 4

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Figura 10. Hoja de ruta de la Tesis Doctoral hasta la Fase 4. Elaboración propia.

BLOQUE VI: Conclusiones sobre los Resultados obtenidos

Figura 11. Hoja de ruta de la Tesis Doctoral y sus conclusiones. Elaboración propia.

Resumen

Introducción: Visiones estereotipadas y poco favorecedoras del proceso de envejecimiento vinculan persona mayor e invalidez. Muchas veces, incluso el propio entorno del mayor es el que cuestiona esta validez y acalla su voz. Si a esto añadimos que, tanto el proceso de enfermedad como las instituciones y equipos involucrados en la respuesta sanitaria suponen un elemento hostil que intimida y confunde a los pacientes mayores, el deseo de la persona mayor de ser escuchado y participar en su cuidado aparece lastrado por un doble sentimiento de inferioridad: por su edad y su condición de enfermo. Estas circunstancias plantean un escenario desfavorecedor para el desarrollo del paciente mayor como persona y para la óptima participación del mayor en su propio proceso de enfermedad. El empoderamiento de la persona mayor y la sensibilidad de las instituciones hacia las preferencias del paciente, el reconocimiento de su derecho a elegir y su consideración como parte activa del cuidado, podrían evitar esta vivencia por parte del mayor.

Objetivos: Analizar las relaciones de poder y dominación en la atención sanitaria a personas mayores en el entorno comunitario; identificar y distinguir categorías interpretativas de personas mayores y de profesionales (sistema formal) respecto a la atención sanitaria al mayor; explorar el proceso por el que estos elementos se conectan, identificando factores influyentes y consecuencias; describir situaciones de toma de decisiones y participación activa de las personas mayores en la atención; evaluar si las situaciones anteriores coinciden con situaciones de cuidado sensibles a las preferencias de los mayores; relacionar los valores hegemónicos entre las personas mayores y el sistema formal de cuidados con los comportamientos profesionales, en términos de respeto del derecho de la

persona a elegir y de participación activa en el cuidado; identificar diferencias culturales que afectan a la interpretación de la situación.

Metodología: La presente tesis doctoral toma como principal referencia la perspectiva de la opresión, utilizada frecuentemente como marco conceptual para el estudio, y la comprensión de aquellos procesos y fenómenos en los que las relaciones de poder juegan un papel primordial. Además, se adoptó la perspectiva de los Estudios Críticos del Discurso desde su aproximación sociocognitiva propuesta por Teun Van Dijk, para explicar cómo el discurso y la ideología contribuyen a la reproducción de la desigualdad y la injusticia social, determinando quiénes tienen acceso a estructuras discursivas, y de comunicación, aceptables y legitimadas por la sociedad. De forma complementaria, se realizaron dos acercamientos metodológicos para reforzar al Análisis Crítico del Discurso, siendo estos la fenomenología crítica y la meta-síntesis de estudios cualitativos primarios.

Resultados: El discurso de las personas mayores que vivían solas en sus domicilios demostró una autopercepción del estado de envejecimiento negativa, consecuencia de una discriminación por edad percibida a raíz de actitudes edadistas provenientes del personal sanitario que les atendía cuando hacían uso de los servicios de salud. La discriminación por edad fue la telaraña sociocognitiva principal a lo largo de todos los estudios, haciendo que las personas mayores ocuparan un papel inferior en las relaciones de poder con el personal sanitario de atención primaria. Los elementos comunicativos demostraron tener gran presencia, además del contexto situacional y comunicativo del binomio personal sanitario-paciente mayor, en el momento de construcción de las relaciones de poder. Las situaciones de toma de decisiones

compartida, escucha activa de preferencias y participación activa en los cuidados acabaron por ser un fenómeno dinámico y volátil, de naturaleza fuertemente comunicativa y eje principal de las relaciones de poder. El constructo sociocultural de género apareció entre pacientes mujeres mayores y enfermeras de atención primaria para dar cuenta del alcance del componente ideológico en los cuidados, el cual se dividía entre un paternalismo y una discriminación apabullantes, además de un sistema sanitario también opresor con las enfermeras de atención primaria, quienes veían en ocasiones con frustración la dificultad de llevar a cabo una praxis enfermera deseada. El contexto cultural se erigió con fuerza en un entorno de vulnerabilidad para enfermeras migrantes españolas y personas mayores noruegas. La experiencia de choque cultural para las primeras fue crucial para entender la repercusión del mismo en los cuidados conferidos, situando a las enfermeras migrantes españolas en una situación más equilibrada en las relaciones de poder mantenidas con las personas mayores noruegas. La experiencia transcultural adquirida reforzó su identidad como enfermeras y fijó los valores de respeto a la autonomía de las y los pacientes.

Conclusiones: El estudio crítico de las relaciones de poder establecidas entre el personal sanitario de atención primaria y las personas mayores usuarias de servicios de salud que vivían solas en sus domicilios a través del análisis crítico del discurso, resultó ser de gran complejidad y estar acompañado por numerosos elementos que se interrelacionaban entre sí. El contexto, las actitudes ideológicas, las estrategias discursivas, el género o la cultura son tan solo algunas piezas del tablero del poder entre relaciones discursivas. La persona mayor sufre de discriminación por edad en numerosas ocasiones. El personal sanitario sufre de condiciones laborales poco favorecedoras en otras ocasiones. Las circunstancias

sociales, cognitivas y discursivas son tan variadas como esenciales para entender el vaivén de las relaciones de poder entre ambos grupos sociales.

Abstract

Introduction: Stereotyped and unflattering visions of the ageing process link older people and disability. Many times, even older people's environment is the one that questions this validity and silences their voices. If we add to this that the disease process, the institutions, and teams involved in the health response represent a hostile element that intimidates and confuses older patients, the older person's desire to be heard and participate in their care appears weighed down due to a double feeling of inferiority: their age and condition as a patient. These circumstances pose an unfavourable scenario for the development of the older patient as a person and for the optimal participation of the older people in their disease process. The empowerment of older people and the sensitivity of the institutions towards the patient's preferences, the recognition of their right to choose and their consideration as an active part of care could prevent this discriminatory experience.

Objectives: To analyse the power relations and domination in healthcare for older people in the community setting; to identify and distinguish interpretative categories of older people and professionals regarding healthcare for older people; to explore the process by which these elements are connected, identifying influencing factors and consequences; to describe situations of shared decision-making and active participation of older people in care; to assess whether the above situations coincide with care situations sensitive to the preferences of older people; to relate the hegemonic values between older people and the formal care system with professional behaviours, in terms of respect for the person's right to choose and active participation in care; to identify cultural differences that affect the interpretation of the situation.

Methodology: This doctoral thesis takes as its primary reference the perspective of oppression, frequently used as a conceptual framework for the study and the understanding of those processes and phenomena in which power relations play a fundamental role. In addition, the perspective of Critical Discourse Studies was adopted from its sociocognitive approach proposed by Teun Van Dijk to explain how discourse and ideology contribute to the reproduction of inequality and social injustice, determining who has access to discursive structures, and communication, acceptable and legitimised by society. In a complementary way, two methodological approaches were carried out to reinforce Critical Discourse Analysis: critical phenomenology and the meta-synthesis of primary qualitative studies.

Results: The discourse of older people who lived alone in their homes demonstrated a negative self-perception of the ageing process, a consequence of perceived age discrimination due to ageist attitudes from the health personnel who attended them when they used health services. Age discrimination was the leading sociocognitive web throughout the study, causing older people to occupy a subordinate role in power relations with primary care health personnel. The communicative elements proved to have a significant presence, in addition to the situational and communicative context of the healthcare staff-older patient pairing, at the time of building power relations. The situations of shared decision-making, active listening to preferences and active participation in care ended up being a dynamic and volatile phenomenon, intensely communicative in nature and the central axis of power relations. The sociocultural construct of gender appeared among older women patients and primary care nurses to account for the scope of the ideological component in care, which was divided between

overwhelming paternalism and discrimination, in addition to a health system that was also oppressive with primary care nurses, who sometimes saw with frustration the difficulty of carrying out a desired nursing praxis. The cultural context was strongly erected in an environment of vulnerability for Spanish migrant nurses and Norwegian older people. The experience of culture shock for the former was crucial to understanding its impact on the care provided. It placed Spanish migrant nurses in a more balanced situation in the power relations maintained with Norwegian older people. The acquired cross-cultural experience reinforced their identity as nurses and set the values of respect for patients' autonomy.

Conclusions: The critical study of the power relations established between primary care health personnel and older people users of health services who lived alone in their homes through critical discourse analysis turned out to be highly complex and accompanied by many interrelated elements. The context, ideological attitudes, discursive strategies, gender or culture are just a few pieces on the power board between discursive relationships. Older adult suffers from age discrimination on numerous occasions. Health personnel suffer from unfavourable working conditions at other times. The social, cognitive and discursive circumstances are as varied as they are essential to understand the fluctuations in power relations between both social groups.

Sammendrag

Introduksjon: Stereotype og lite flatterende visjoner om aldringsprosessen knytter eldre mennesker og funksjonshemninger sammen. Mange ganger er til og med eldre menneskers miljø det som stiller spørsmål ved denne gyldigheten og gjør stemmene deres stille. Legger vi til dette at sykdomsprosessen, institusjonene og teamene som er involvert i helseresponsen representerer et fiendtlig element som skremmer og forvirrer eldre pasienter, fremstår den eldres ønske om å bli hørt og delta i deres omsorg tynget på grunn av en dobbel. følelse av mindreverdighet: deres alder og tilstand som pasient. Disse omstendighetene utgjør et ugunstig scenario for utviklingen av den eldre pasienten som person og for optimal deltakelse av de eldre i deres sykdomsprosess. Myndiggjøring av eldre mennesker og institusjonenes følsomhet overfor pasientens preferanser, anerkjennelsen av deres rett til å velge og deres hensyn som en aktiv del av omsorgen kan forhindre denne diskriminerende opplevelsen.

Hensikter: Å analysere maktforhold og dominans i helsevesenet for eldre mennesker i lokalsamfunnet; å identifisere og skille tolkningskategorier av eldre mennesker og fagpersoner angående helsetjenester for eldre mennesker; å utforske prosessen som disse elementene er forbundet med, identifisere påvirkningsfaktorer og konsekvenser; å beskrive situasjoner med delt beslutningstaking og aktiv deltakelse av eldre mennesker i omsorg; å vurdere om ovennevnte situasjoner sammenfaller med omsorgssituasjoner som er følsomme for eldre menneskers preferanser; å relatere de hegemoniske verdiene mellom eldre og det formelle omsorgssystemet med profesjonell atferd , i form av respekt for personens rett til å velge og aktiv deltakelse i omsorgen; å identifisere kulturelle forskjeller som påvirker tolkningen av situasjonen.

Metode: Denne doktorgradsavhandlingen tar som sin primære referanse perspektivet undertrykkelse, ofte brukt som et konseptuelt rammeverk for studiet og forståelsen av de prosessene og fenomenene der maktforhold spiller en grunnleggende rolle. I tillegg ble perspektivet til Critical Discourse Studies adoptert fra dens sosiokognitive tilnærming foreslått av Teun Van Dijk for å forklare hvordan diskurs og ideologi bidrar til reproduksjon av ulikhet og sosial urettferdighet, og bestemmer hvem som har tilgang til diskursive strukturer, og kommunikasjon, akseptabel og legitimert . av samfunnet. På en komplementær måte ble to metodiske tilnærminger utført for å forsterke kritisk diskursanalyse : kritisk fenomenologi og metasyntesen av primære kvalitative studier.

Resultater: Diskursen til eldre som bodde alene i hjemmet viste en negativ selvoppfatning av aldringsprosessen , en konsekvens av opplevd aldersdiskriminering på grunn av alderistiske holdninger fra helsepersonellet som deltok i dem når de brukte helsetjenester. Aldersdiskriminering var det ledende sosiokognitive nettet gjennom hele studien, og fikk eldre til å innta en underordnet rolle i maktforhold til primærhelsepersonell. De kommunikative elementene viste seg å ha en betydelig tilstedeværelse, i tillegg til den situasjonelle og kommunikative konteksten til sammenkoblingen mellom helsepersonell og eldre pasienter, på tidspunktet for bygging av maktrelasjoner. Situasjonene med delt beslutningstaking, aktiv lytting til preferanser og aktiv deltakelse i omsorgen endte opp med å bli et dynamisk og flyktig fenomen, intenst kommunikativt av natur og den sentrale aksen for maktforhold. Den sosiokulturelle konstruksjonen av kjønn dukket opp blant eldre kvinnelige pasienter og primærsykepleiere for å redegjøre for omfanget av den ideologiske komponenten i omsorgen, som var delt mellom overveldende paternalisme og diskriminering, i tillegg til et helsesystem

som også var undertrykkende med primærsykepleiere, som noen ganger med frustrasjon så vanskeligheten med å gjennomføre en ønsket sykepleiepraksis. Den kulturelle konteksten ble sterkt reist i et sårbart miljø for spanske migrantsykepleiere og norske eldre mennesker. Opplevelsen av kultursjokk for førstnevnte var avgjørende for å forstå dens innvirkning på omsorgen som ble gitt. Den plasserte spanske migrantsykepleiere i en mer balansert situasjon i maktforholdet til norske eldre. Den ervervede tverrkulturelle erfaringen forsterket deres identitet som sykepleiere og satte verdiene om respekt for pasientenes autonomi.

Konklusjoner: Den kritiske studien av maktrelasjonene etablert mellom primærhelsepersonell og eldre brukere av helsetjenester som bodde alene i hjemmet gjennom kritisk diskursanalyse viste seg å være svært kompleks og ledsaget av mange sammenhengende elementer. Konteksten, ideologiske holdninger, diskursive strategier, kjønn eller kultur er bare noen få brikker på kraftbordet mellom diskursive relasjoner. Eldre voksne lider av aldersdiskriminering ved en rekke anledninger. Helsepersonell lider av ugunstige arbeidsforhold til andre tider. De sosiale, kognitive og diskursive omstendighetene er like varierte som de er essensielle for å forstå svingningene i maktforhold mellom begge sosiale grupper.

Bloque I Consideraciónes Teoórico-Conceptuales de la Tesis Doctoral

Capítulo I: Introducción al Análisis Crítico del Discurso

Sección I: Antecedentes y principios histórico-ontológicos

Resulta cuanto menos estimulante, comenzar las líneas que perfilan la tinta de esta tesis doctoral, cuestionando la nomenclatura empleada tanto en el título —que apenas a pocos centímetros encabeza esta sección—, como en el que da precisamente nombre a mi Tesis Doctoral. Sea, pues, el espíritu crítico de la disciplina que he ido sembrando a lo largo de todo este *viaje*, el que ya empiece a dar señales de vida, llamando a las cosas por su verdadero nombre: lo que tradicionalmente se ha conocido y conoce como Análisis Crítico del Discurso (ACD) —y que aún hoy perdura en el léxico científico—, ha venido transformándose en lo que las mismas personas expertas y pioneras del área rebautizaron como Estudios Críticos del Discurso (ECD) (Wodak & Meyer, 2015).

Las palabras de van Dijk (T. A. Van Dijk, 2009) atribuyen como principal "raison d'être" de esta mutación al hecho de que, todo aquello que abarca el ACD no debe restringirse a un análisis aplicado, pues además guarda en su seno concepciones filosóficas, teóricas, metodológicas y prácticas que hacen de la denominación de ACD una etiqueta autolimitante.

Los ECD pretenden, en cierta forma, relacionar teorías propias del área del lenguaje con teorías sociales. El porqué de este ánimo reside en que las personas estudiosas críticas del discurso *estudian* a la sociedad a través del discurso, tratando de contextualizarlo y, paulatinamente, comprenderlo a través de un análisis adaptado a los cimientos históricos, sociopolíticos y culturales sobre los que se edifica —en un sentido aglutinador de la palabra— el discurso. No solo

eso, los ECD podrían ser referidos como una investigación disidente, ya que las personas analistas críticas del discurso se posicionan explícitamente en su constante búsqueda de entender, exponer y desafiar la desigualdad social (T. A. Van Dijk, 2015). Es por ello por lo que los ECD también pueden ser considerados como un movimiento social políticamente comprometido.

Bien podríamos considerar a los ECD como un determinado conjunto de acercamientos interdisciplinarios, todos ellos orientados hacia el lenguaje, que pretenden desgranar el papel que juega el uso del mismo en la creación y perpetuación de estructuras de la sociedad, así como de procesos de índole social y, eventualmente, cambios sociales (Flowerdew & Richardson, 2018). Y es que de los ECD emana una importante influencia proveniente de teorías sociales, que espolea una pesquisa —lingüística mediante— hacia una aproximación crítica que revele problemáticas cuya naturaleza resida en la ideología, el poder y la desigualdad. Estos tres elementos constituyen el eje vertebral sobre el que se articula cualquier tipo de investigación enmarcada en este campo.

Por otro lado, además de tener claro hacia dónde vamos, es necesario considerar de dónde venimos, y los ECD se relacionan fundamentalmente, por definición, con la investigación cualitativa. No por ello, también puede ser combinada con otros métodos cuantitativos, aunque no pertenezca naturalmente a ellos. De hecho, como un espejo que refleja una mirada, se ha demostrado a lo largo de recientes descubrimientos en análisis de corpus asistidos, que la dimensión cuantitativa puede ser introducida para complementar y soportar al análisis cualitativo discursivo (Anthony & Baker, 2015).

Una cuestión de suma importancia, que cualquier persona lectora de esta tesis debe tener en cuenta, y que desde este mismo momento tan temprano me gustaría destacar, es que el punto de mira de los ECD no queda limitado

meramente a un estudio lingüístico del discurso: incluso tampoco a cualquier estudio del discurso que sea principalmente de carácter empírico o analítico, pues, ¿dónde quedaría el componente *crítico* tan característico de los ECD en tal caso?

Más bien, y al contrario que otras aproximaciones cercanas al Análisis del Discurso (AD), los ECD están cosidos, como si de un cuerpo a su sombra se tratase, a la máxima de analizar casos provenientes del "mundo real", en los que el lenguaje sea una herramienta que hay que utilizar y no un fin, teniendo al texto como principal unidad analítica en dicho ejercicio. Dicho de otro modo, las personas analistas críticas del discurso comulgan en la visión del lenguaje como una forma de práctica social, cuyo enfoque reside en el contexto que rodee al uso que se haga del lenguaje en un momento puntual (Fairclough, 2001; T. Van Dijk, 2011; Wodak & Meyer, 2015).

Veremos que el uso del lenguaje va necesariamente vinculado a *sociedad*, pues el hecho de utilizar, de usar el lenguaje, es adoptar un comportamiento social *per se* (Fairclough, 2001).

Como una brizna de hierba que sigue al viento, los ECD se vieron fuertemente inspirados por los trabajos de Austin (Austin, 1975) y Wittgenstein (Wittgenstein, 2010), quienes catalogaron el uso del lenguaje como una práctica, una acción social, otorgando la pincelada connotativa de movimiento, actuación: una puesta en marcha que requiere un *por* qué y un *para* qué. Una intención.

Una intención que aflora de un *yo* (una acción interpersonal y/o institucional) que posee una serie de principios, valores e ideas (una acción sociocultural) y que persigue un fin (una acción material). Una intención es a la acción, lo que el discurso es al uso del lenguaje.

Por tanto, los ECD deben ser una aproximación dirigida a una problemática y no a una teoría, y la gran baza a jugar por su parte debe ser desentrañar las verdaderas intenciones veladas que una persona hablante teje, cual moira griega, en el momento del uso del lenguaje y denunciarlas en voz alta. Digámoslo así: la persona analista crítica del discurso hace explícito lo implícito del uso del lenguaje, como una intervención forense (Jaworski & Coupland, 1999), como si fuera un quirurgo que toma la empuñadura de un bisturí para después deslizarlo, ejerciendo una presión milimétrica sobre el lenguaje, con una animosidad licenciosa.

Tal y como se ha destacado al comienzo de esta sección, los ECD se llevan a cabo en un abanico muy amplio de disciplinas, obviando los estudios lingüísticos; unas más oriundas en la antropología, sociología y ciencias de la comunicación o políticas, otras más afines a una vertiente sanitaria, como puede ser la psicología o, en el caso que nos ocupa, la enfermería.

La simiente de los ECD puede recogerse, si nos retrotraemos un siglo atrás, en la teoría crítica de la escuela francfortesa alemana (Agger, 1992; Drake, 2009). Sin embargo, en el corazón de los ECD late, históricamente, la Lingüística Crítica (LC).

La LC fue cultivada —sobre todo— por la escuela lingüística británica (Fowler et al., 2018; Mey, 1985), y pretendía subrayar la importancia de la ideología y las relaciones de poder en la práctica lingüística discursiva, además de la elocuencia y fuerza que sobre dicha práctica tienen determinadas construcciones sintácticas (Fowler et al., 2018; Kress, 1989). Así pues, esta disciplina dirigía su mirada crítica en revelar casos de discriminación y/o de manipulación en el discurso público a través de procedimientos "despertadores de conciencias" (Filardo-Llamas & Boyd, 2017). Desde un punto de vista

histórico, el surgimiento de los ECD puede tener su explicación como un brote reaccionario contra los paradigmas positivistas dominantes de la época de los años sesenta y setenta, que desechaban la esfera social o crítica de sus enfoques.

La investigación crítica sobre el discurso tendría, entre otras, las siguientes características que conformarían la piedra angular de los ECD (T. A. Van Dijk, 2015):

1. Enfoque primordial sobre problemáticas sociales y políticas, por encima de un mero estudio de las estructuras del discurso fuera de los contextos sociales y políticos.
2. Enfoque multidisciplinar en su abordaje analítico y crítico sobre dichas problemáticas.
3. Enfoque explicativo de las estructuras discursivas, en términos de cómo medran las interacciones sociales enmarcadas en, a su vez, estructuras sociales.
4. Enfoque vehicular sobre las formas en las que las estructuras discursivas hacen acto de presencia, se confirman, legitiman, reproducen o desafían las relaciones de abuso de poder en la sociedad.

Asimismo, en la **Figura 1** aparecen condensados los principios propuestos por Fairclough & Wodak sobre los ECD (Fairclough et al., 1997), para mayor detalle.

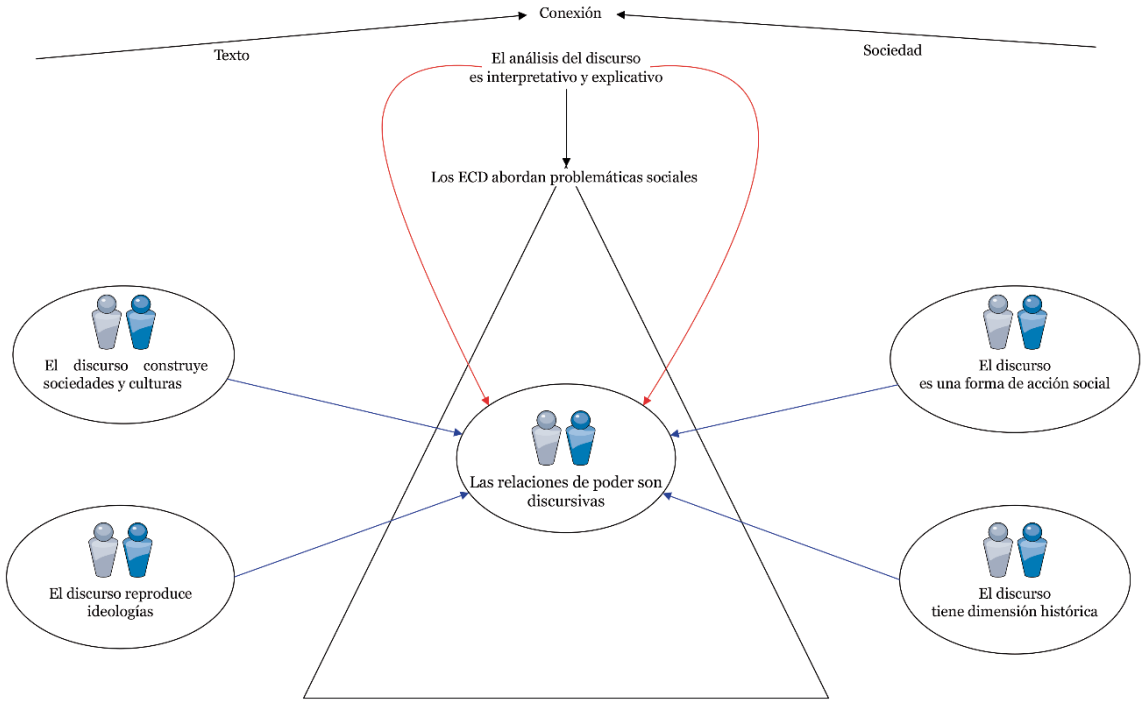

Figura 1. Principios propuestos por Fairclough & Wodak (1997) sobre los ECD. Elaboración propia.

En cualquier caso, el discurso y el lenguaje serán vistos como un diálogo, una relación binomial que se mantiene como una mano que se acomoda sobre otra, siendo esta segunda las estructuras sociales. Podemos decir que las estructuras sociales, por un lado, afectan al discurso. Pongamos como ejemplo un ejercicio de agencia discursiva butleriana (Butler, 1997, 2004), en la que una persona es interpelada de manera ofensiva, pero que, tras un proceso discursivo de desvío identitario, asume esa nueva identidad no como algo ofensivo, sino como algo legítimo. Este ejercicio que acabo de ejemplificar existe "gracias" a las fuerzas encorsetadas e impuestas por convenciones sociales, ideologías y relaciones de poder.

Por otro lado, podríamos decir que el discurso afecta a las estructuras sociales. El discurso, más allá de "solamente" representar una realidad social, (re)crea un

mundo social y establece conexiones dentro del mismo. Pongamos como ejemplo, sin ir más lejos, una enfermera y un paciente que interactúan de manera específica y, en cierta forma, predecible: la relación que se establece entre ambas personas a través del discurso y su contexto, es un manifiesto social de un entorno clínico, plagado de códigos semánticos, situacionales e interactivos, y de un mapa jerárquico de identidades profesionales, personales y —en definitiva—, sociales (Tajfel & Turner, 2004). Por todo esto, el discurso es entendido como una *huella* vital en la generación del saber y del significado.

Sección II: Conceptos clave

Epígrafe a: Discurso

El término discurso es tan amplio como específico, en función de hacia dónde pretendamos dirigir nuestra mirada. El discurso puede ser referido al uso del lenguaje en términos generales. En este caso, *discurso* pasaría a ser un sustantivo incontable, genérico. En los ECD, la palabra discurso se puede utilizar para referirse a un conjunto de significados expresados a través de una serie de mecanismos y formas concretas, cuyo fin es el de permitir la expresión de unas instituciones o grupos sociales en concreto (Kress, 1989). Si utilizamos esta definición, *discurso* sería, en esta ocasión, un sustantivo contable, dotando de especificidad a la palabra, pudiendo sub-etiquetar los tipos de discurso a discurso edadista, machista, feminista, racista, sexista, y así durante un largo etcétera de términos creados mediante una misma sufijación. La particularidad aquí es que cada tipo de discurso permanece caracterizado por una determinada ideología que, a su vez, se identifica mediante un conjunto de expresiones lingüísticas, semióticas y sociales, en definitiva.

Para sentar las bases de mis investigaciones a lo largo de Tesis Doctoral, he de hacer hincapié en que entendí al discurso desde una postura claramente interactiva y práctica, debido al bagaje que mis manos brizan sobre mi profesión y formación académico-clínica en enfermería. Es por ello que asocié al discurso a una parte de su naturaleza: a la oralidad.

Numerosos trabajos sobre el discurso concebido como acción social se centran en la conversación y el diálogo, más concretamente conocidos como el *habla* (T. A. van Dijk, 2019b). Si nos referimos a la fracción oral del discurso, hemos de hacer mención a su contraparte escrita, ya que mientras la naturaleza conversacional del habla tiene un lazo con la práctica social, también existe dicho

vínculo entre la acción social y la escritura y lectura. No obstante, la vasta diferencia entre discurso oral y escrito radica en que el primero exige —en términos históricos del ser humano y obviando el colosal avance de la tecnología en nuestro siglo— un encuentro cara cara entre personas usuarias del lenguaje, que a su vez toman partido de una serie de interacciones comunicativas enmarcadas en un cambio de turnos de palabra. Si tenemos, por un lado, a varias personas interaccionando oralmente mediante un sistema de turnos, quiere decir que la información que recibe una, va a ser incorporada a la respuesta que dedicará a la otra, y viceversa, de forma que una persona hablante reacciona al discurso que pronuncie otra persona hablante previa.

El discurso hablado, en un gran porcentaje de los casos, es espontáneo e improvisado (Saíz, 2006), generando pausas, coletillas, repeticiones, interrupciones y un explayado etcétera de circunstancias puntuales. El discurso escrito, sin embargo, suele ser más controlado y meditado en la medida en que la inexistencia de una persona hablante física que nos acompañe nos da cierta pausa y tiempo de acción añadido para gestionarlo.

Pero si un apunte es cierto, es que existe una gama de colores que confluyen entre ambos polos del discurso. El caso es que, en efecto, existen situaciones en el discurso oral que pueden haber sido trabajadas previamente mediante textos escritos, y luego reproducidos mediante el habla. Una entrevista semiestructurada, entre una persona investigadora y una persona entrevistada, puede tener como protagonista un guion con una serie de preguntas generales sobre los que hacer girar la dinámica de la indagación, preparado con anterioridad, por ejemplo. Al mismo tiempo, un género discursivo escrito puede no guardar el principio de control que se mencionó anteriormente, pues un

simple mensaje mediante una red social no tiene por qué reunir los elementos que desembocan en una escritura preparada.

El estudio del discurso como acción o práctica social, por tanto, no debe sencillamente corresponderse con un acercamiento al análisis conversacional de un diálogo surgido de manera casual, ni a un uso del lenguaje meramente oral, pues muchos géneros discursivos integran monólogos, diálogos con partes escritas y habladas, pudiendo ser espontáneos o preparados en función del momento y necesidad de las personas hablantes (T. A. van Dijk, 2019b).

Epígrafe b: Poder

Otra dimensión, pues, destacable y necesaria para entender la práctica social que representa el discurso, y las relaciones que se derivan de la misma, es el poder. De acuerdo a Foucault (Foucault, 1982), el poder es un concepto ubicuo en la sociedad, entendido por las personas analistas críticas del discurso como medio de manutención del control sobre personas o grupos sociales. Una teoría consistente con los ECD desde esta perspectiva, es la Teoría de la Hegemonía de Gramsci (Bates, 1975), explicativa de cómo el poder es utilizado no ya como coerción física, sino de manera análoga por medio de la ideología y el discurso. De acuerdo con lo que Gramsci declara, existe una cultura hegemónica sustentada por una clase privilegiada, que propaga sus propias creencias, principios, valores y normas de tal manera que, tanto el poder como la autoridad que representa, llegan a ser concebidas como el *statu quo* social. Dicho de otra manera, la hegemonía resultante del ejercicio del poder es una condición mediante la cual los grupos vulnerados aceptan o consienten la autoridad social de otro grupo, sin la necesidad de una fuerza física —en este sentido, la fuerza acecha más bien en una vigilia latente y abastracta durante la práctica social— (Cox, 2004).

Una hegemonía institucionalizada y exitosa logra que los grupos sociales subordinados consientan el liderazgo de los privilegiados, consiguiendo, por ende, dominar y que su imperante ideología campe a sus anchas. De esta forma, el concepto de poder hegemónico responde a la incógnita planteada de cómo los grupos sociales vulnerados aceptan unas relaciones de poder desequilibradas con respecto a grupos sociales vulnerantes: los grupos privilegiados implantan su sistema de creencias y valores con un uso mínimo de fuerza explícita, gracias a la

alfombra roja desplegada por los grupos perjudicados y a la legitimidad político-social otorgada a los primeros.

Con Gramsci (Bates, 1975) en mente, el secreto del equilibrio de la hegemonía lo guarda el contrapeso entre fuerza y consenso social: podrá haber algún desajuste, pero jamás la fuerza deberá exceder al consenso para permanecer sibilina en su propósito.

Para lograr que el consenso apoye a la fuerza, un plebiscito debe aprobarlo, y eso es algo que se refleja de igual manera desde las instituciones discursivas pertinentes, como asociaciones, gobiernos o sistemas (Gramsci, 1971). Así, los grupos hegemónicos se nutren de otros grupos no hegemónicos. Para esto es esencial que el grupo vulnerado, a pesar de identificar los valores abanderados del grupo vulnerante, no opte por rebelarse o levantarse en resistencia.

Esta relación de poder hegemónico y desequilibrado es, desde un punto de vista discursivo, catalogada como hegemonía discursiva (Fairclough, 2003). Siguiendo la estela del discurso, el poder discursivo puede ejercerse de tres maneras distintas, según Holzscheiter (Holzscheiter, 2005), siendo:

1. *Dentro* del discurso, donde los y las hablantes se disputan la interpretación del significado de los actos de habla discursivos.
2. *Sobre* el discurso, donde los y las hablantes se incluyen o excluyen con relación a un acto de habla discursivo.
3. *Desde* el discurso, donde los actos de habla discursivos lleven a cabo un control sobre los y las hablantes. Esto, a pesar de que en ocasiones, las personas tengan sutiles destellos de agencia, y se atrevan a detener discursivamente el ejercicio del poder, en detrimento del grupo poderoso.

El poder social, pues, es definido en términos de control (T. A. van Dijk, 2017). Aquel grupo social que consiga controlar los actos y mentes de las personas integrantes de otros grupos sociales tendrán una habilidad cuya base del poder se identificará con un acceso privilegiado a recursos como la fuerza, la economía, el estatus, el conocimiento, la información, la cultura o, por supuesto, formas de discurso público o estrategias discursivas (Mayr, 2008).

Entre las muchas y distintas formas de ostentar poder se encuentran el poder económico, militar o el denominado poder persuasivo, siendo este el que ejercen padres y madres, profesoras y profesores o personas expertas en algún área sobre las que tengan un recurso vital de conocimiento, información o autoridad (T. A. van Dijk, 2017). Definitivamente, el poder es un egoísta seductor que recela de ser compartido, por lo que no siempre, todas las personas integrantes de un grupo poderoso, de hecho, lo son más que todas las personas integrantes de los grupos dominados.

En los análisis sobre las relaciones entre discurso y poder enmarcados en los ECD, el acceso a formas concretas de discurso —propias de la educación, la ciencia o la sanidad— es, en sí mismo, una fuente de poder (T. A. van Dijk, 1995). Por ello, el concepto de poder cobra una envergadura mayor al establecer un vínculo especial entre los recursos discursivos y la influencia que estos pueden tener sobre las acciones sociales de otras personas. Y las acciones sociales de otras personas influenciadas previamente por estrategias discursivas, son controladas por acciones mentales. Por esto mismo, si un discurso dominante es capaz de moldear la mente de un determinado grupo social, indirectamente está esculpiendo sus acciones por medio de una persuasión y manipulación. Como broche de oro en este círculo de poder, aquellas personas que controlen un

discurso tremendamente influyente tendrán más capacidad para controlar las acciones sociales y la mente de otras personas que haya detrás de ellas.

Epígrafe c: Crítica

El gran eje sobre el cual basculan los ECD y las personas analistas críticas del discurso, es la noción de crítica. La crítica podría conceptualizarse como aquella actitud investigadora cuya principal motivación radica en desafiar la injusta y desigual distribución de poder entre grupos sociales, mediante el análisis de unos discursos empleados por las personas integrantes de dichos grupos, que demuestre unas desigualdades —también discursivas— a través del texto oral u escrito (Reisigl, 2008). De esa forma, la puesta en marcha de tareas crítico-analíticas también origina otro de los grandes adalides de esta actitud inquisitiva: resolver problemas específicos en la comunicación, con el objetivo de mejorar los procesos comunicacionales y las relaciones surgidas a raíz de ellos.
Según Hegel (Grumley, 2006), la crítica no debe ser entendida solamente como un juicio condicionado por connotaciones negativas, sino como un ejercicio positivo de función emancipadora. Así pues, la crítica es la madre de la autocrítica, tan necesaria para deconstruirse y después aprender desde los cimientos de la humildad intelectual y de la ética profesional, algo tan evidente como necesario en la profesión enfermera.

En cierta forma, el fin último de un ACD debe ser abocar a las personas analistas críticas del discurso a un prolegómeno de cambio social o, al menos, servir de bastón a la resistencia (T. A. Van Dijk, 2009). Igualmente, haciendo un símil con mi profesión, la misión de la crítica es *cuidar* a los grupos desfavorecidos confiriéndoles un hálito de acompañamiento y sostener la

posibilidad —aunque remota, en numerosas ocasiones— de hallar justicia en forma de un re-equilibrio en las relaciones de poder.

Por su parte, Wodak & Meyer (Wodak & Meyer, 2009) presentan tres maneras de abordar la crítica en su Aproximación Histórico-Discursiva (AHD) a los ECD:

1. Crítica inmanente del discurso. Su orientación se dirige a bucear en las prácticas discursivas para detectar contradicciones internas, inconsistencias o dilemas que pongan de manifiesto debilidades en el discurso.
2. Crítica socio-diagnóstica. Se alimenta de teorías sociales y de la riqueza informativa del contexto donde se reproduzca el texto —discurso—, con el objetivo de señalar la naturaleza manipuladora de determinadas prácticas discursivas.
3. Crítica pronóstica. A modo de broche, aglutina las perspectivas provenientes de las críticas anteriores para contribuir a la mejoría de una comunicación deteriorada.

En cualquier caso, e independientemente de la orientación que se tome como referencia, la crítica debe basarse sobre valores éticos, como la honestidad, la integridad, la transparencia, la responsabilidad y el respeto, pues el verdadero propósito de la crítica es servir de enclave para una revisión de aquellas actuaciones o situaciones que sean susceptibles de deconstruir, en pos de una mejoría y desde una humildad intelectual (Titscher et al., 2000).

Aludiendo al carácter emancipador de la crítica, hay una fuerte diferenciación con aquellas prácticas sociales acríticas, que buscan orientar su *modus operandi* hacia lares donde la representación social transmitida por el

discurso sea dominante, con el objetivo de enraizar a lo largo del paso del tiempo determinadas jerarquías sociales, mientras que un ACD persigue fisurar y disrumpir la idiosincrasia del discurso dominante, y preguntarse sobre la necesidad de aparición de discursos de resistencia, de tal forma que el futuro del orden socio-político vaya adquiriendo una forma cada vez más equilibrada (Macgilchrist, 2016). En este sentido, y guardando cohesión con la "agenda social" de los ECD, Rogers califica este conjunto de actitudes y propósitos como una "agenda reconstructiva" (Rogers, 2004), mientras que Martin se refiere a estas aproximaciones crítico-discursivas como un Análisis del Discurso Positivo, con claras connotaciones solidarias y comprometidas con la sociedad (Martin, n.d.).

Epígrafe d: Identidad

Un concepto importantísimo y determinante, en la comprensión necesaria de las esferas sociocognitivas a analizar mediante los ECD, es el de identidad. La identidad es una construcción social compleja, abstracta y fluida, que cambia a lo largo del tiempo y el espacio interpersonal: hace referencia a la forma (o formas) con la que una persona (o grupo) se dirige, por un lado, tanto a los y las demás integrantes de una sociedad, y por otro lado, a sí misma, además de en comparación con los y las demás integrantes de esa sociedad (Brown & Lunt, 2001; Tajfel, 1981; Tajfel & Turner, 2004).

Tal y como he colocado entre paréntesis previamente, la identidad puede hacer referencia a un conjunto variopinto de distintas formas de expresarla, por lo tanto, una identidad puede ser múltiple (Davies & Harré, 1990; P. V. Kroskrity, 2022), y he aquí una diferenciación clave: una persona posee una identidad individual, y otra identidad grupal, pudiendo ser ambas distintas entre sí, no necesariamente las mismas, pero igualmente con posibilidad de ser combinables

ya que forman parte de una autobiografía lineal y no contradictoria (Davies & Harré, 1990).

La identidad se manifiesta a través de la práctica social que se realice en un momento determinado por una persona o grupo, y una parte crucial e inherente de la misma, tal y como he ido mencionando, es la práctica discursiva. Por ello, la identidad también es representada hacia y entre otros colectivos sociales a través del discurso (Kress, 1989). Por ejemplo, en mitad de una conferencia de un alto cargo de gestión perteneciente a un colectivo político-sanitario, se puede generar una imagen profesional de enfermería correspondiente a la de una identidad de sacrificio hasta la extenuación, "necesario" durante la pandemia mundial de COVID-19 para salvaguardar la salud de la población afectada. Sin embargo, estas proyecciones de identidad pueden o no ser aceptadas como propias, por parte de los colectivos aludidos (Chiapello & Fairclough, 2002).

Las construcciones identitarias están imbuidas de relaciones de poder e ideología, por lo que los ECD se tornan apropiados para conceptualizar y analizar los procesos de construcción de identidad social. Al fin y al cabo, esto cobra sentido si observamos que desde la misma definición de identidad, existe una comparativa entre grupos. Las palabras de Tajfel & Forgas (Tajfel & Forgas, 2000) resuenan en este epígrafe, pues nosotros y nosotras somos quienes somos, porque ellos y ellas no son quienes somos. Y es que la cuestión es la siguiente: la identidad es normalmente utilizada como un instrumento de agencia y como una fuente de significado (Castells, 2011), con el fin de describir una cierta sensación de pertenencia, reflejando asimismo la necesidad imperante que tenemos los seres humanos de definirnos entre nosotros y nosotras y al resto: a los otros y otras (Duszak, n.d.).

Kroskrity (P. Kroskrity, 2000) tiene a la identidad como una construcción lingüística de una membresía de grupo. De esa forma, el lenguaje es la llave que abre la puerta a construir y (re)formar nuestras identidades. Por otro lado, Davies & Harré (Davies & Harré, 1990) enuncian que el *yo* es un constructo constituido a través de procesos de interacción social. Como consecuencia de dichos procesos, también declaran, de una bellísima manera, que el quiénes somos siempre será una pregunta abierta con una respuesta cambiante.

Atendiendo a la concepción de identidad de Kroskrity previamente definida, las identidades son representaciones establecidas o reproducidas comunicativamente: aquí la identidad es desplegada, como una *performance* a través del lenguaje, al cual se le considera como un indicador de identidad (P. Kroskrity, 2000). Siguiendo con el concepto de *performance*, Bauman (Bauman, 2000) considera que las interpretaciones —acojámonos a la connotación actoral de la palabra— lingüísticas son una especie de *status loci* donde la identidad se construye.

Sin embargo, la dimensión de identidad es conflictiva en la medida que aun hoy en día, gran parte de la investigación es llamativamente vaga en términos ontológicos de la identidad. Mientras que las nociones postestructuralistas conciben a la identidad como algo que el ser humano construye —y, por tanto, no ajena al mismo—, otras corrientes deconstructivas o antiesencialistas critican el concepto de la misma trabajado por el AD: se ha adoptado el mantra de que la identidad es una construcción, que a su vez ha causado que no se necesite mayor investigación o cuestionamiento acerca del origen de la propia identidad (Hall, 2011). Si la identidad es una construcción del ser humano, podemos entonces concluir que estamos tratando con dos realidades *construidas* y representadas a través del discurso. Pero, ¿qué ocurre si atribuimos a la identidad una función de

interpretación de elementos que ya existen en nuestro entorno (Versluys, 2007)? ¿Acaso significa eso que la identidad también es un elemento pre-existente al que solo le damos forma a través del discurso? ¿Hasta qué punto debe ser entonces considerada como una construcción? Serán los ECD y otras áreas del conocimiento los que deban encontrar respuesta.

Epígrafe e: Ideología

Siguiendo la pista al epígrafe a) y a la definición de discurso, la ideología es el común denominador en todas las sub-etiquetas del mismo. Una ideología, en términos afines a la temática que nos ocupa, se podría definir como un conjunto de creencias y valores pertenecientes a un grupo social en particular.

La ideología rocía nuestra percepción del mundo social y los discursos con los que interaccionamos dentro del mismo. Es algo más que un determinado fardo de conceptos que portamos y (re)hacemos a medida que vamos acumulando experiencia vital: es un constructo que se va perfilando a lo largo y ancho de nuestras interacciones sociales, producto resultante de un prisma predefinido por un espacio, tiempo y grupo social en el que nos encontramos (Vološinov, 1986).

Lo más fascinante desde un punto de vista discursivo, en cuanto a la ideología, es que esta detenta una valiosísima capacidad de ser diseminada, cual virus por vía aérea, para el beneficio de un grupo social específico. Y es ahí donde la cruzada entre el "*Nosotros"* y el "*Ellos"* insurge como aquella intencionalidad de erigir un muro en pos de una diferenciación positiva del endo-grupo (el "*Nosotros*") versus negativa del exo-grupo (el "*Ellos*") (Brown & Lunt, 2001).

En este sentido, y a modo ilustrativo con referencia a van Dijk (T. van Dijk, 2000), en la **Figura 2** muestro los mecanismos clave de esta cruzada en la que el acero lo empuña la práctica discursiva, con el objetivo de ensalzar la

representación discursiva endo-grupo y mancillar la representación discursiva exo-grupo.

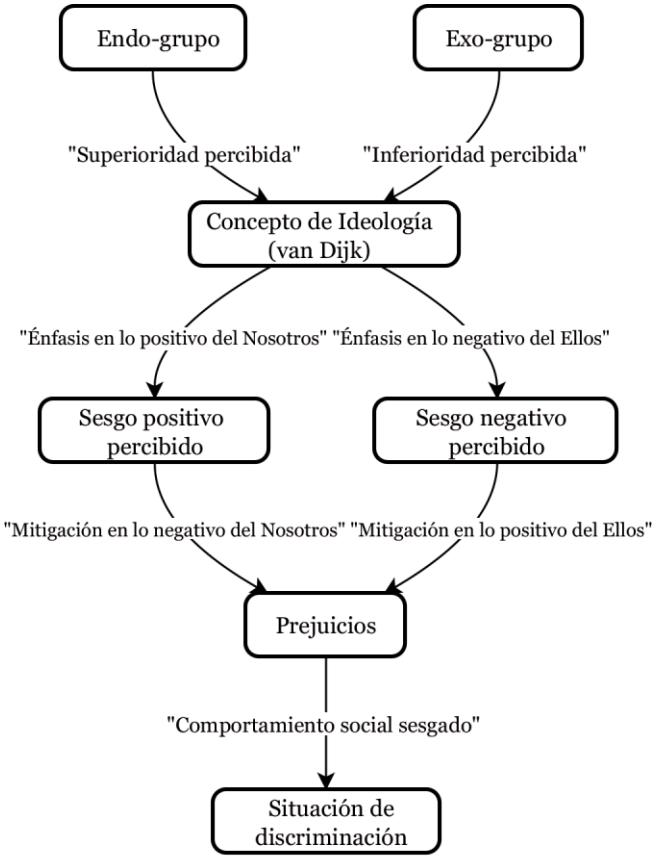

Figura 2. Mecanismo de actuación del cuadrado ideológico de van Dijk (2000). Elaboración propia.

Sin embargo, tal y como se empieza a vislumbrar, la ideología no se limita solamente al conjunto de creencias y valores. Va más allá: la ideología son maneras de pensar cuyo propósito es el de empañar la percepción de la realidad en determinados grupos sociales, de manera que la organización social sea esculpida poco a poco, transitoria e históricamente, con el fin de imponerse y hacer unánime una percepción forzada sobre dicha realidad, para que sea vista como eterna, natural e inevitable (Jones, 2001).

Me apasiona definir la ideología como una mano que mece la cuna de la mente, en cuyo regazo se encuentra el entramado social al que pretende mantener

encadenado en una caverna, con el propósito de fabricar una realidad acorde a sí misma (Lombana, 2014).

Pero ¿cómo es posible que una ideología pueda mantener un régimen tan impuesto como sucinto, sobre una realidad social y que sea perpetrada históricamente? Según van Leeuwen (Leeuwen, 2008), y Hodge & Kress (Hodge & Kress, 1993), la respuesta está en el proceso de legitimización ideológica. El proceso de legitimización hace acto de presencia cuando un conjunto de creencias, valores y formas de pensar —esto es, ideología— son aceptadas por la sociedad en la medida que también es aceptada la autoridad que se encarga de imponerla. De esa manera, la perpetuación de la ideología vendrá condicionada con el poder que la autoridad diseminadora de ideología ostente, en un determinado marco social.

Epígrafe f: Contexto

Los ECD no podrían concebirse sin prestar minuciosa atención a la contraparte del texto: el contexto. El contexto, según Fairclough (Fairclough, 2001), embebe todas aquellas circunstancias que cubran la producción, distribución y recepción en la sociedad de un texto ya sea oral u escrito, a su vez influenciadas por un mundo predominantemente cultural y económico. Sea pues, que desde un punto de vista del AD, sea necesaria analizar la relación comprendida entre los textos, procesos y condiciones sociales, dentro de las cuales debemos diferenciar las condiciones inmediatas del contexto situacional, y las condiciones remotas de instituciones y estructuras sociales (Fairclough, 2001).

Al mismo tiempo, Fairclough identifica tres niveles distintos de integración en el AD (Fairclough, 2007): en primer lugar, el análisis del texto, que se ocupa de los correspondientes subniveles lingüísticos a los cuales el corpus de

estudio invite a acercarse; en segundo lugar, el análisis de prácticas discursivas, centradas en la esfera de producción, distribución y consumo del discurso; en tercer lugar, el análisis de prácticas sociales, donde el nivel-micro del texto está condicionado por el nivel-meso de las prácticas discursivas, al mismo tiempo influenciado por el nivel-macro de la práctica social, aglutinando al poder con un rol central en el mismo.

Esta relación, a priori lineal, podría parecer a nuestra mirada una carta de navegación predefinida. Sin embargo, las relaciones establecidas entre todos los niveles son de naturaleza interactiva, circular e iterativa, que conlleva un continuo diálogo entre un análisis-micro del texto, y un análisis-macro de estructuras sociales y la forja de relaciones de poder, ensalzando el rol mediador que las prácticas y procesos discursivos tienen en ella (Richardson, 2017). Esta visión de retroalimentación y dependencia entre las fases de la investigación, conjuga a la perfección con los principios científicos de la investigación cualitativa en Ciencias de la Salud, empleada en gran medida en el área de Enfermería (Britten, 2011; Lincoln & Guba, 1985).

En sintonía con un análisis del contexto, Wodak circunscribe cuatro niveles dentro del mismo (Wodak & Forchtner, 2018):

1. El contexto situacional inmediato.
2. Textos y discursos de los que se nutre el texto.
3. Las condiciones de producción, distribución y recepción del texto.
4. El marco socio-político en el que se encuentre el texto.

De igual forma, Wodak enfatiza en la importancia de la intertextualidad y la recontextualización, donde un elemento de algún texto es incorporado en otro distinto. Debido a que, en ese instante, tenemos un caso de creación de nuevos

significados a través de ese elemento recontextualizado, inevitablemente pasa a ser susceptible de manipulación y, por consiguiente, de control.

No obstante, para mayor entendimiento del escenario analítico de los ECD, no perdamos la oportunidad de ahondar en los niveles que componen al orden social que se someterá al análisis crítico.

En cuanto al nivel micro-analítico, encontramos aquí al uso del lenguaje, el discurso, la interacción verbal y la comunicación. Con respecto al nivel macro-analítico, tenemos el poder, el dominio y desigualdad entre grupos sociales. Todo este conjunto de elementos nos susurra al oído que los ECD deben alfombrar la "brecha" entre las aproximaciones al ACD micro (inherentes a lenguaje) y macro (inherentes a lo social) (Alexander, 1987; T. A. van Dijk, 2019a; Huber, 1991; Knorr-Cetina & Cicourel, 1984). En un día a día lleno de veinticuatro horas de encuentros, vivencias, emociones y experiencias, los niveles micro y macro (y los más intermediarios niveles meso) se funden, derritiéndose en uno solo. Por ejemplo, un discurso edadista en una consulta de enfermería en atención primaria, ante un paciente mayor, es un discurso enmarcado en el nivel micro como interacción interpersonal dentro de una determinada estructura social, en una situación específica de entrevista motivacional, pero, al mismo tiempo, promulga o es constituyente de una reproducción del edadismo, en un nivel macroestructural desde un punto de vista de un sistema sanitario con ideología paternalista.

¿Cómo es posible, entonces, puentear la brecha micro-macro para así encallar el navío analítico en orillas de un análisis crítico unificado? La respuesta a esta pregunta la veremos en el último epígrafe de la sección I del capítulo I perteneciente al Bloque II.

Capítulo II: Aproximaciones a los Estudios Críticos del Discurso

Tal y como Van Dijk declama (T. A. Van Dijk, 2013; Wodak & Meyer, 2009), los ECD no son una metodología de investigación *per se*, sino un conjunto de aproximaciones variadas y como tal, con una nutrida variedad idiosincrática y metódica. Sin embargo, hay algo que sí tienen en común, siendo este elemento unificador la actitud académico-crítica que la persona investigadora impregna al momento de aplicar los principios teóricos de los ECD, representando así una de las grandes diferencias entre el AD y el —todavía y también denominado— ACD.

Por lo tanto, dado que los ECD no son métodos (Titscher & Jenner, 2000) y ante la necesidad de detallar la aproximación a los ECD que se va a realizar por no existir un marco teórico unitario, en la **Figura 3** es posible apreciar algunas de las más conocidas y consolidadas aproximaciones —teniendo en cuenta sus perspectivas críticas— a los ECD (Fairclough, 2001; Jäger & Maier, 2009; eeuwen, 2008; Mayr & Machin, 2012; T. A. Van Dijk, 2009; Wodak & Meyer, 2009).

Figura 3. Aproximaciones a los ECD destacadas. Elaboración propia.

A pesar de esta variedad, todas ellas comparten algo, y es que, todas ellas, liban de varias teorías tanto de naturaleza lingüística como ajenas a la misma.

Sobre las primeras, destacan la Lingüística Funcional Sistémica (LFS), la Pragmática y, en los últimos tiempos en auge, se encuentra la Lingüística Cognitiva (LCg). Sobre las segundas, sobresalen teorías socio-cognitivas y teorías socio-críticas, y ante estas últimas sería posible mencionar una decena de ellas, pero sobre todo, merece la pena recordar conceptos que representan un lecho sobre el cual los ECD se acomodan, como la relación entre *habitus*, poder y género en Bourdieu, las visiones críticas sobre las relaciones de poder y sociedad en Foucault y Habermas, o el vínculo entre clases sociales y poder dentro de un panorama social occidento-capitalista en Marx (Bourdieu, 1990; Foucault, 1982; Postone et al., 1995; Thompson & Held, 1982).

Dentro de esta amalgama de aproximaciones a los ECD, numerosas personas analistas críticas del discurso han enfatizado la importancia de la dimensión

histórica de cualquier AD (Achugar, 2008), debido a que, cuando damos forma al significado de lo que decimos, damos continuidad a nuestra experiencia personal en un mundo social, conectando en un momento particular en el espacio-tiempo pasado, presente y futuro. De hecho, en cada instante, somos "tocados" hermosamente por las acciones de otros y otras, con los y las que coexistimos y con los y las que hemos coexistido con anterioridad: me apasiona pensar que somos un ser vaporoso, que flota discursivamente por el horizonte del tiempo (Heidegger, 1951; Lorca, 1995).

Continuando la estela histórica del discurso, y si debemos referirnos a una importante persona autora practicante de los ECD, habríamos de referenciar a Fairclough en su trabajo *Discurso y Cambio Social* (Fairclough, 1993), donde expuso la necesidad de que cualquier aproximación al discurso y al cambio social, debería ser un método de análisis histórico. Desde un nivel textual del discurso, esto podría demostrarse a través de la identificación de cómo las relaciones intertextuales resaltan los cambios acontecidos en la estructura social.

Otra estudiosa crítica del discurso que emplea un acercamiento histórico a los ECD, es Wodak con su AHD (Wodak & Meyer, 2009), quien enfatiza que el contexto histórico debería ser siempre analizado e integrado en la inferencia de los discursos y sus textos. Aquellos ECD con AHD trabajan en demostrar, ciertamente, la función de la intertextualidad y la recontextualización en los engranajes discursivos. Además, Reisigl (Reisigl, 2008) apunta que, en el mundo de hoy día, somos constantemente desafiados por una horquilla de cambios políticos, económicos y ecológicos a todos los niveles propios de naciones y sociedades. Por ello, una AHD es más que pertinente para ser aplicada en los ECD, con el propósito de estudiar todos estos cambios (Achugar, 2008; Flowerdew, 2012).

Si nos referimos a su abordaje metodológico, las diversas aproximaciones a los ECD incluyen un acercamiento tradicional al análisis cualitativo de textos, así como en forma de análisis de corte pragmático-discursivo pero también, al mismo tiempo, recogen la utilización de instrumentos propios de métodos fenomenológicos y etnográficos como son las entrevistas, los grupos focales o la observación participante (Flowerdew & Richardson, 2018), algo que casa perfectamente con la metodología empleada en investigación cualitativa en Ciencias de la Salud, y más concretamente, en la disciplina enfermera.

En cuanto al corpus de estudio analítico, los ECD se encargan de diseccionar el discurso político-ideológico proveniente de varios géneros, tanto escritos como audiovisuales, como pueden ser extractos de prensa, discursos, material gráfico de propaganda electoral; de textos provenientes de los medios de comunicación como extractos de periódicos, revistas, rótulos televisivos o cinematográficos; de documentos históricos y oficiales, como archivos históricos o diarios; de material proveniente de internet; de material de naturaleza fenomenológico-etnográfica traído mediante observaciones, entrevistas o grupos focales. En cuanto al tamaño del corpus, y como consecuencia del origen de este, varía en un rango bastante amplio que puede ir desde apenas unas líneas escritas de una conversación vulgar y cotidiana, hasta decenas o cientos de textos de cualquier parte del mundo y cuestión.

Capítulo III: Desavenencias contra los Estudios Críticos del Discurso

No obstante, los ECD no están carentes de detractores. Los ECD sufren enjuiciamientos por posibles sesgos de la persona analista crítica del discurso durante el proceso de selección e interpretación de los textos a analizar (Blommaert, 2005), por resultar una disciplina demasiado determinista (Hammersley, 2002), o por redirigir las interpretaciones a su favor (Jones, 2001; STUBBS, 1994).

Sería naíf considerar que en ningún campo de estudio se estuviera exento de crítica. Como en todos los vértices donde intervenga un ser humano, podremos encontrar una gama cromática de buenos y no tan buenos trabajos.

Lo que tenemos en nuestra mano las personas analistas críticas del discurso, para mitigar las posibles problemáticas a nuestros enfoques analíticos, es un ejercicio de humildad, transparencia y honestidad intelectual. Dicho de otro modo, explicar de manera clara y detallada, en qué consiste la información recolectada y cómo fue recolectada; reflejar el contexto relevante del corpus analítico en detalle; realizar un ejercicio de reflexividad posicionándose desde la sinceridad vis a vis con los datos recabados; realizar una reflexión introspectiva sobre el qué y el cómo se está trabajando a lo largo del proceso investigador; esforzarse en desempeñar una triangulación de los resultados mediante el empleo de metodologías de investigación, herramientas de recolección de datos y análisis complementarios; considerar múltiples perspectivas y mantener una actitud abierta ante las mismas, a lo largo del proceso de interpretación de los datos,

incidiendo en una escisión entre la interpretación del *yo* personal y del *yo* investigador (Calderón, 2002; Guba, 1981; Joseph et al., 2021).

Dados los ejemplos anteriores, y siguiendo en nuestro mapa mental una hoja de ruta acorde a unos criterios de rigor y veracidad en el proceso investigador, podremos sortear una praxis deficiente que asegure alcanzar los hitos de investigación en los ECD.

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Bloque II Consideraciones Teóricos-Metodológicas de Tesis Doctoral

Capítulo I: Aproximación sociocognitiva: Análisis Cognitivo del Discurso[1]

A lo largo de mi Tesis Doctoral, he comprendido la aproximación sociocognitiva de van Dijk (Van Dijk, 2009) como el enfoque que necesitaba dar a mi investigación sobre las relaciones de poder establecidas entre enfermeras de atención primaria y personas mayores que residían solas en sus hogares.

La pincelada sociocognitiva que ofrece van Dijk en la visión del discurso y sus relaciones garantiza el papel primordial de los procesos mentales involucrados en cómo nos relacionamos las personas en nuestro mundo social (T. A. van Dijk, 2017; Van Dijk, 2009). Así, los modelos mentales representan el eslabón que faltaba para entender la relación existente entre texto y contexto; entre texto y estructura social. Y es que resulta esencial, desde un punto de vista teórico, concebir que no hay otra forma posible de relacionar los niveles *macro* del discurso —como el dominio, control y desigualdad—, con los niveles *micro* del discurso en sus nociones de texto, actos de habla, significados y comprensión. Por supuesto, si tenemos en cuenta el discurso como vehículo de reproducción del poder, resulta necesaria la concepción de que, en efecto, si el discurso contribuye a reproducir un dominio basado en el control, debemos asumir que hay algo más que deba unir sociedad y discurso: los procesos mentales, o dicho de otro modo, la cognición. Los diferentes niveles del discurso, desde el texto hasta el contexto, pasando por las consecuencias sociales de una reproducción del poder, son todas piezas de ajedrez que ocupan una casilla en el tablero que es la cognición social.

[1] Para la confección de la totalidad del Capítulo I perteneciente al Bloque II, tuve como principal y gran referente el trabajo de van Dijk sobre la aproximación sociocognitiva en los ECD (V. Dijk, 2015).

De tal manera, la cognición social sonríe a las estructuras discursivas en la medida en que las estructuras discursivas le devuelven la sonrisa a la cognición social.

Un acercamiento cuya base son los modelos mentales también ha sido empleado por Hart (Hart, 2014a) —entre otros—, aunque de manera más profunda incidiendo en dichos modelos, y llegando a introducir consideraciones teóricas ya desde la LCg. De hecho, la LCg ve al lenguaje como una condición *sine qua non* para entender la propia cognición en términos generales, siendo su misión la de identificar relaciones directas entre patrones del lenguaje y patrones del pensamiento. Un ejemplo por antonomasia de esta aproximación sería la Teoría de la Metáfora Conceptual de Lakoff & Johnson (Lakoff & Johnson, 1980) —al mismo tiempo practicada por algunas personas analistas del discurso en acercamientos tan interesantes como el análisis crítico-metafórico (Charteris-Black, 2004)—, que trata de identificar patrones ideológicos silentes entre metáforas conceptuales en el discurso. Otra contribución de Hart (Hart, 2014b) al panorama discurso-cognitivo fue la de no ceñirse solamente al océano metafórico, sino considerar ya al patrón lingüístico-gramatical como un pilar en su relación con la ideología y el contexto.

Centrándome en van Dijk, el enfoque sociocognitivo se fundamenta en lo que él denomina el triángulo Discurso-Cognición-Sociedad (V. Dijk, 2015). Mientras que todos los acercamientos a los ECD se edifican en la relación discurso-sociedad, la aproximación sociocognitiva enuncia que esa relación está mediada desde la cognición. Las estructuras discursivas y sociales son ontológicamente diferentes, y solo pueden ser conectadas a través de representaciones mentales[2] de personas usuarias del lenguaje, que cumplen un

[2] Las representaciones mentales, según la psicología cognitiva, son entidades conceptuales que se despliegan en la mente, entendiéndola como un espacio de representación (Bower & Cirilo, 1985).

rol individual y colectivo desde el punto de vista de grupo social. Por ende, la interacción, situación y estructura social pueden influenciar el texto y el habla a través de las inferencias que las personas hagan de ese entorno social. Inversamente, el discurso solo puede influenciar la interacción y estructura social a través de la misma interfaz cognitiva donde se ubican los modelos mentales, el conocimiento, las actitudes e ideologías.

En el área de la psicología, la mediación cognitiva de los procesos mentales es algo innegable. Sin embargo, en el área del AD, aún hoy día existe cierta reticencia a abrazar la cognición como nexo a lo que es socialmente "observable" (V. Dijk, 2015). Si no se tuviera en cuenta el panorama cognitivo en el discurso, los subniveles lingüísticos dejarían de tener sentido para ser analizados, como la semántica o la pragmática, ya que su naturaleza no es a simple vista observable, sino más bien encaminada a conductas reflejadas a través de representaciones cognitivas[3] mentales. Más concretamente, esto es demostrable desde el mismo momento en que asumimos que las personas usuarias del lenguaje no solo actúan comunicativamente mediante el habla, la escritura, la escucha o la lectura: pues piensan antes de ello, y luego, hacen.

[3] Las representaciones cognitivas, según la psicología cognitiva, son el conjunto de conocimientos o creencias que se representan en la memoria o mente (Bower & Cirilo, 1985).

Sección I: Componentes del enfoque sociocognitivo

Epígrafe a: Sobre la Mente

A pesar de que tanto fuera como dentro de los ECD el componente cognitivo no está tan consolidado como otros elementos considerados como cruciales, merece un esfuerzo dedicar especial atención a los elementos que lo componen. Haciendo un recorrido por el acercamiento sociocognitivo de van Dijk (V. Dijk, 2015; Van Dijk & Kintsch, 1983), los tres pilares básicos de la estructura cognitiva serán los siguientes:

1. **Memoria**. La memoria o mente, normalmente se suele dividir en dos segmentos conceptuales: la Memoria a Corto Plazo (MCP) —también denominada como Memoria de Trabajo— y la Memoria a Largo Plazo (MLP). La MLP despliega recuerdos de experiencias autobiográficas y conocimiento almacenados en la Memoria Episódica (ME), por un lado, y de forma más general acoge conocimiento social compartido, actitudes e ideologías en la Memoria Semántica, por otro lado. La MCP se encarga de poner atención a los procesos inmediatos, decisiones y cambios recientes, además de proferir información sobre el contexto local donde la persona se encuentre y en un determinado momento.
2. **Modelos mentales**. Envuelven nuestras experiencias personales procesadas en la MCP, tan subjetivas como únicas, dando lugar a modelos individuales latentes en nuestra ME. Estos modelos mentales se distribuyen en una estructura jerárquica estandarizada bajo una configuración que comprende el entorno, las personas participantes de ese entorno —así como sus identidades, roles y relaciones—, acciones o

eventos, y metas u objetivos. Estas categorías mentales también reflotan en las estructuras semánticas de las oraciones que pronunciamos y que describen nuestras experiencias personales. Los modelos mentales, además, son multimodales: despliegan información visual, auditiva, sensomotora, evaluativa y emocional de experiencias que vivimos, procesadas por nuestro cerebro en compartimentos distintos.

3. **Cognición social**. La gran diferencia entre el concepto anterior y el que nos ocupa reside en que, mientras que los modelos mentales son personales, únicos e intransferibles, la cognición social hace referencia a la capacidad que tenemos los seres humanos de compartir conocimiento, como una red neuronal a la que estuviéramos todas y todos conectados, cual panal de abejas cuyas celdas representaran una parcela compartida socio-cognitivamente. Y es que todas las personas tenemos un conocimiento genérico y abstracto del mundo que habitamos, que compartimos con otras personas integrantes de nuestra comunidad epistemológica. Exactamente por esa misma razón, somos parte de un grupo social específico, en el que también compartimos actitudes (acerca de la inmigración, de la eutanasia, de la gestación subrogada, sobre las personas mayores o sobre otro largo etcétera) vinculadas a una ideología que las fermenta, como puede ser el racismo, el machismo o el edadismo; a una ideología que las rechaza, como puede ser el antirracismo, el feminismo o la intergeneracionalidad. Serán nuestras propias experiencias, pues, las que se interpretarán, construirán y representarán a raíz de nuestros modelos mentales, que estarán a su vez germinadas por una base de cognición social. Entonces, del mismo modo en que compartimos grupo social con personas semejantes, también

compartiremos modelos mentales de forma más o menos semejante con pares dentro de ese mismo grupo social: estos rasgos vitales de la cognición humana permitirán una cooperación, interacción y comunicación o, en otras palabras, la existencia del discurso.

Epígrafe b: Sobre el Procesamiento mental del Discurso

La pregunta aquí, ahora, es: ¿cómo se procesa y (re)produce el discurso? Si tenemos como referencia las tres estructuras cognitivas básicas, la microestructura discursiva (palabras, oraciones, párrafos o turnos de palabra) es secuencialmente procesada por la MCP, traduciéndose en una representación de la macroestructura discursiva por medio de una gestión de modelos mentales, conocimiento e ideologías, por la MLP.

Dentro del procesamiento del discurso, podríamos distinguir entre dos tipos de modelos mentales distintos (V. Dijk, 2015):

4. **Modelos situacionales**. Representan la situación que abarca *aquello* a lo que el discurso se refiera, aquel tema central *sobre* el que trate y, dada esa apostilla acerca del "*significado* situacional", se denominan, también, modelos semánticos (Van Dijk & Kintsch, 1983). Así pues, este tipo de modelo da cuenta del significado personal que tiene el momento discursivo, a raíz de una interpretación que hace de él la persona, otorgándole una coherencia local y global a una situación comunicativa específica y a un momento determinado. Por otro lado, no dejan de ser representaciones subjetivas de eventos, acciones o situaciones *sobre* el quid de la cuestión.
5. **Modelos de contexto**. De naturaleza dinámica y cambiante, representan la volátil situación o experiencia comunicativa *dentro* de la cual las personas usuarias del lenguaje están constante e irregularmente inmersas. Como todo modelo mental, tienen un fuerte componente subjetivo: de ahí que representen cómo cada participante entiende e interioriza la situación

comunicativa. Estos modelos serán los que definan la pertinencia contextual del discurso que se vaya a emplear, con respecto a la situación comunicativa correspondiente. Además, es gracias a este tipo de modelo mental que las personas hablantes sean capaces de transmitir opiniones y emociones sobre una situación concreta. Por esta connotación sobre su naturaleza *interpretativa*, estos modelos son también denominados modelos pragmáticos. No solo controlan qué información del modelo situacional es o no apropiada para iniciar o mantener una conversación, sino también la *forma* en la que esa decisión se *debe* materializar. Por ejemplo, cualquier persona puede contar la misma experiencia de cómo lleva sus estudios de doctorado (por tanto, un mismo modelo mental), de manera distinta a personas allegadas y a personas desconocidas (por tanto, diferentes modelos de contexto).

Epígrafe c: Sobre el Conocimiento, su génesis y mecanismo mental

El terreno sobre el cual se erige toda cognición —y con ello, todo pensamiento, percepción, entendimiento, interacción y discurso—, es el conocimiento que adquirimos a lo largo de nuestra vida, individual y compartido con otras personas de nuestra comunidad desde un punto de vista epistemológico (V. Dijk, 2015). Aunque aún en nuestros días desconocemos con total precisión cómo se organiza minuciosamente el conocimiento en nuestra mente, es asumible concebir que, al menos, existe cierta jerarquía categórica de conceptos y esquemas conceptuales de diferentes tipos, así como retazos de episodios cotidianos, esquemas mentales de objetos o personas mismas. El conocimiento se podría definir en tal caso como un set de creencias que casan con el criterio —siempre evolucionando históricamente— epistémico de una comunidad en particular. El conocimiento socialmente compartido, en particular, se moldea por medio de la generalización de modelos mentales individuales, basados en experiencias de vida, percepciones e interpretaciones de eventos y situaciones. Esto es posible gracias al siempre presente vehículo que es el discurso, que transmite dichas experiencias vitales de manera directa, como un consejo que una madre o padre da a su hijo o hija.

Concretamente ahí reside el "secreto" del conocimiento socialmente compartido: las relaciones entre el conocimiento y el discurso son esenciales, pues la inmensa mayoría de conocimiento que adquirimos de manera no empírica —en otras palabras, que no hemos experimentado en nuestra vida— lo hacemos a través del discurso oral u escrito, al mismo tiempo que para la producción y comprensión del discurso, resultan necesarias vastas cantidades de conocimiento socialmente compartido. Dado que el conocimiento de las personas participantes

es vital para todo el curso de procesamiento del discurso, al igual que el desarrollo de la conversación y la interacción derivada de la misma, el mero hecho de usar ese conocimiento ya hace que se convierta en un elemento más de la situación comunicativa.

He ahí, pues, un ingrediente más que añade complejidad a los modelos de contexto: el dispositivo de conocimiento. El dispositivo de conocimiento se correspondería con una especie de engranaje mental cercano a la metacognición que, como si de un cuentagotas se tratase, irá pautando, regulando y bombeando una determinada cantidad de conocimiento para compartir y que, al mismo tiempo, irá calculando cuánto conocimiento está siendo ya compartido entre las personas integrantes de la situación comunicativa, por lo que se irá tejiendo, en primer lugar, el panorama a presuponer —la presuposición hace referencia a una determinada información que la persona hablante "da por hecho" y que, en teoría, todo el mundo lo conoce— y, en segundo lugar, el panorama a descubrir —información novedosa que las personas desconocen hasta ese momento—.

En relación con los ECD, es fundamental concebir el conocimiento como un recurso de poder. Aquellos grupos sociales que tengan un acceso privilegiado a determinadas especialidades o *píldoras* de conocimiento tendrán también una valiosa herramienta de manipulación y control sobre el discurso y, por tanto, sobre otras personas y las acciones de estas.

Como ejemplo, podría ser el discurso enfático positivo proveniente de una persona política sobre el número de hospitales inaugurado recientemente por su partido, para así manipular la opinión pública a su favor. Este discurso podría soslayar otro tipo de información complementaria que podría ser el equipamiento deficiente de dichos hospitales, los recursos humanos insuficientes o las condiciones laborales de los contratos que se realicen, de manera que crease una

imagen pública de compromiso social, sesgando el conocimiento adquirido por el pueblo hacia un polo del espectro político.

Epígrafe d: Sobre las Actitudes y las Ideologías

Las actitudes e ideologías son un conjunto de creencias sociales que solo son compartidas por grupos sociales específicos (V. Dijk, 2015). Un ejemplo podría ser que, a pesar de que la mayoría de las personas sepa qué es el aborto o la eutanasia, no todas mantienen una misma actitud ante ese conocimiento socialmente compartido: puede ser una actitud positiva o negativa, prohibitiva o concesiva, dependiendo de ideologías subyacentes. De la misma forma que desconocemos —paradójicamente— cómo se articula exactamente el conocimiento en nuestra mente, tampoco sabemos con seguridad la estructura mental precisa de estas actitudes socialmente compartidas. A pesar de ello, sí sabemos que se rigen por una lógica esquemática. Por ejemplo, que alguien sostenga una actitud en contra de la gestación subrogada puede desplegar creencias sobre la identidad, origen, valores, acciones y propósitos de las personas que la lleven a cabo, creando una relación entre el "*Nosotros*" y el "*Ellos*" que asocie evaluaciones positivas o negativas en función de sus normas y valores.

Las actitudes tienden naturalmente a basarse u organizarse por obra y gracia de ideologías que controlan la adquisición y adaptación de determinadas actitudes. Así, una ideología edadista puede controlar actitudes negativas y estereotipadas (Levy, 2009) hacia las personas mayores, a su vez repercutiendo en la manera en que ellas se ven a sí mismas y su autonomía para llevar a cabo el proceso la toma de decisiones sobre su propia salud, su derecho a ser escuchadas o a participar ellas mismas en sus cuidados.

Tal y como he enunciado anteriormente con respecto a las actitudes, desconocemos el orden y organización interna exacta en la disposición de las

ideologías. No obstante, tampoco quedan exentos los elementos que salen a flote, normalmente, cuando trabajamos con ideologías: identidad, actividad, propósitos, relaciones con otros grupos sociales e intereses. Todos estos conceptos son inherentes a la definición de grupo social, especialmente en la disputa entre el "*Nosotros*" y "*Ellos*", una lucha polarizada que pretende controlar el poder mediante su abuso, la dominación, la competición feroz entre grupos contrarios y la cooperación entre grupos afines, al mismo tiempo que teñir de ideología al discurso.

Los untuosos tentáculos de las ideologías, aparte de controlar actitudes específicas, también atrapan experiencias personales o, dicho de otro modo, modelos mentales de otras personas integrantes de grupos de ideología semejante. De hecho, en un discurso ideológico, apreciaremos una representación positiva del endo-grupo y una representación negativa del exo-grupo (T. A. van Dijk, 2017; Tajfel, 1981; Tajfel & Turner, 2004), mediante el uso de subniveles del lenguaje escrito o hablado como el léxico empleado, las descripciones que se hagan, la argumentación que se esgrima, las historias contadas o las metáforas que como un papel mojado, tiñen al discurso de una evaluación ideológica sesgada, por ejemplo.

Epígrafe e: Sobre el papel del Elemento Cognitivo en los Estudios Críticos del Discurso

Tras todo lo el camino emprendido hasta ahora, existe evidencia suficiente para considerar al componente cognitivo como elemento clave en una teoría del discurso, en general, y para los ECD, en particular (V. Dijk, 2015).

El poder y el abuso de este, la dominación y manipulación, de igual manera que otras formas ilegítimas de discurso, interacción y comunicación son el líquen que convive de manera simbiótica con las estructuras sociales y el desequilibrio de poder en las relaciones entre diferentes grupos en la sociedad.

Sin embargo, ya que los ECD tienen un componente o actitud crítica, deben ir más allá de la mera identificación de estructuras lingüísticas y su relación con los grupos sociales: deben rascar la superficie del mundo social que habitamos, y encontrar una explicación sobre cómo las complejas estructuras sociales influencian, a su vez, las estructuras del uso del lenguaje en términos de texto y habla, y viceversa.

Para hallar una comunión entre esta búsqueda del porqué de las cosas, y servirnos de esa explicación para señalar situaciones de desigualdad social, debemos dirigir nuestra mirada al "subterfugio" del discurso, aquello que se empeña en escaparse de entre nuestras rendijas analíticas, camuflarse, pasar desapercibido para no perder poder e influencia: la mente.

Para ello, resulta fundamental comprender el pegamento que une discurso y sociedad; concienciarnos de la existencia de una mediación cognitiva entre ambos.

Si el discurso estuviera solamente conectado con la sociedad, todos los discursos en las mismas situaciones sociales serían exactamente iguales. O

imaginémoslo de la siguiente manera: independientemente de quién se trate, reproducirá exactamente el mismo discurso ante una misma situación social. Empero, se torna imprescindible un mecanismo cognitivo que regule y adapte, por medio de modelos mentales, la interacción entre ambos elementos. Por lo tanto, los modelos semánticos y pragmáticos son los que dotan de unicidad a los encuentros discursivos enmarcados en una determinada estructura social. En cualquier caso, las estructuras cognitivas que están detrás de todo proceso socio-discursivo, pueden permanecer silentes o, por el contrario, reflejar explícitamente ideologías a través del texto. Dichas estructuras pueden también manifestarse de forma no discursiva, mediante actos sociales como ejercicios de discriminación, exclusión o violencia directas. Al mismo tiempo, pueden ser estratégicamente adaptadas o negadas en situaciones comunicativas específicas, en las que la persona hablante camufle sus verdaderas intenciones ideológicas.

Epígrafe f: Sobre la Estructura Ideológica del Discurso

Uno de los rasgos más característicos de los ECD es el análisis de las estructuras discursivas que están específicamente involucradas en la (re)producción de situaciones de desigualdad social y de abuso de poder. Dado que el poder y el abuso de este se definen en términos de relaciones establecidas entre grupos sociales, el discurso que los vehiculice estará condicionado por ideologías que integren un plan: una estrategia a seguir para lograr su propósito (*Scripts, Plans, Goals, and Understanding*, n.d.).

Por ejemplo, si una enfermera decidiera no escuchar las preferencias de un paciente mayor en el momento de planificación de visitas domiciliarias, el propósito de no hacerlo irá acompañado de un conocimiento que actuará cual guion que le sirva de instrucciones para saber qué decir, o hacer —a lo largo del encuentro con el paciente mayor—, aferrándose a la jerarquía que le confiere el rol social que ostenta, en contraposición con el de la persona mayor, ambas proyectando representaciones sociales definidas en el momento. Y todo ello se llevará a cabo mediante estructuras discursivas que centelleen actitudes e ideologías sucintas, a la par que dominantes, por parte de grupos sociales que detenten poder.

Las estructuras cognitivo-ideológicas son diferentes a las estructuras discursivas, pero ambas están estrechamente conectadas. De hecho, para llegar a las estructuras ideológicas y poder estudiarlas, transitar primeramente por el discurso a través de su estudio representa una puerta abierta que debe cruzarse para llegar a las primeras.

Si las ideologías siguen una estructura esquemática de categorías básicas como la identidad, actividad, propósitos, relaciones con otros grupos sociales e intereses, estará también caracterizada por estrategias o mecanismos discursivos que

controlen dichas categorías básicas. Algunas de las estructuras discursivo-ideológicas más destacables quedan recogidas en la **Tabla 1** (V. Dijk, 2015).

De igual forma que existen estructuras ideológicas y estrategias que persigan un propósito, deben encontrarse también herramientas lingüísticas que permitan reproducir esas estrategias. Por ejemplo, si pretendemos enfatizar la diferencia entre las cualidades positivas del endo-grupo y las negativas del exo-grupo en un texto escrito (u oral), será común apreciar un uso de titulares, oraciones activas, repeticiones, hipérboles o metáforas. Por el contrario, si la pretensión fuera la de mitigar las cualidades negativas del endo-grupo, será probable encontrar un uso de eufemismos, oraciones pasivas, o información implícita en las declaraciones, entre otros.

Tabla 1. Estructuras discursivo-ideológicas. Adaptación de v. Dijk (2015).

	Descripción de la estructura
Polarización	Sobredimensión de rasgos o características positivas intra-grupo y negativas exo-grupo. Esta desproporción salpica a todos los niveles discursivos.
Uso de pronombres	Uso "político" de pronombres por parte de las personas usuarias del lenguaje. Para referirse a sí mismas como representantes de su grupo (*Nosotros* y sus derivados) con tintes de camaradería y unidad. Para referirse a otros externos a su grupo (*Ellos* y sus derivados) con intención de enfrentar y rebajar. La concepción del "*Nosotros* vs. *Ellos"* relaciona esta estructura con la de polarización. Este distanciamiento negativo también se puede ver reflejada en el uso de adjetivos demostrativos y pronombres posesivos ("*esa gente*", "*los tuyos*", p.ej.)
Identificación	La categoría por antonomasia de las ideologías de grupo es su identidad. Las personas que formen parte de un grupo ideológico se identificarán continuamente con *su* grupo, expresando esa identificación de muchas formas ("*Como enfermera, yo…*", "*Hablando como enfermera, pienso que…*", "*Yo soy enfermero*").
Énfasis en representaciones +/-	Las ideologías siguen una organización esquemática positiva o negativa. Teniendo en cuenta la estructura de polarización, encontraremos un énfasis en las características positivas del intra-grupo y un énfasis en las negativas del exo-grupo, como por ejemplo en un discurso edadista o machista. Por otro lado, las propiedades negativas del intra-grupo tenderán a ser ignoradas de la misma manera en que serán mitigadas las propiedades positivas del exo-grupo. Esta combinación de énfasis hiperbólica y mitigación de cualidades positivas y negativas de intra-grupos y exo-grupos se le denomina el Cuadrado Ideológico.

Epígrafe g: Sobre el Orden Social

Cerrando la última arista del triángulo sociocognitivo, responderé a la pregunta que cerraba la sección II del Capítulo I perteneciente al Bloque I.

A continuación, se describen diversos elementos necesarios para tener en cuenta cuando llegue el momento de analizar y cruzar el puente sobre la brecha social "micro-macro", encarando un ACD como un todo (Van Dijk, 2015). Los binomios pertenecientes al orden social del triángulo sociocognitivo serán:

1. **Grupo-Integrantes del Grupo**. Las personas usuarias del lenguaje toman parte en los procesos discursivos en calidad de integrantes de uno o más grupos sociales, organizaciones o instituciones y, de igual manera, las extremidades de los grupos sociales son sus personas integrantes, actuando *por* y *a través de* ellas.
2. **Acción-Proceso**. Los actos sociales que llevan a cabo las personas son partes constituyentes de procesos grupales mayores, como pueden una determinada legislación o aquel conjunto de actos que reproduzcan actitudes edadistas entre el personal de enfermería y pacientes mayores, por ejemplo.
3. **Contexto-Estructura social**. Todas aquellas situaciones donde se dé el discurso a menor escala formarán parte del maderamen social de mayor escala. Ejemplificando esto, una conferencia de prensa de una persona con un cargo de dirección hospitalaria a nivel provincial pertenece a una práctica discursiva local, que pertenece, a su vez, a una organización o institución superior de la macroestructura social (un sistema sanitario). De esa forma, los contextos locales y globales permanecen estrechamente vinculados y ambos tienen su respectiva influencia en el discurso.

4. **Cognición personal-Cognición social**. Las personas usuarias del lenguaje son actrices sociales que poseen tanto una cognición personal, como social (recuerdos, conocimiento y opiniones), al mismo tiempo que la comparten en cierta medida con otras personas integrantes de su grupo social o cultura. En otras palabras, mientras que otras aproximaciones acentúan que las relaciones entre micro y macroestructuras sociales son concisamente analíticas, el verdadero nexo entre discurso y sociedad es la socio-cognición, pues las personas usuarias del lenguaje utilizan representaciones mentales para conectar ambos niveles.

Sección II: Consecución del Control Mental

Todo medio tiene un fin. Y el fin de los ECD con una aproximación sociocognitiva no es otro que el de desenmascarar las relaciones de poder desequilibradas entre un grupo social que ejerce, en definitiva, un control mental sobre otro grupo social que lo sufre.

Pues, si controlar el contexto y las estructuras del texto y habla son la sublimación del ejercicio del poder, controlar las mentes de las personas a través del discurso es una manera tan indirecta como esencial para reproducir dominio y hegemonía (Van Dijk, 2015). Por supuesto, el control del discurso normalmente va dirigido hacia un control sobre las intenciones, planes, conocimiento, opiniones, actitudes e ideologías de las personas que lo padezcan, además de sus acciones consecuentes.

Un análisis del control mental presupone una distinción entre memoria personal (o autobiográfica) y memoria genérica, socialmente *semantizada* (Tulving, 2002). Adentrémonos, pues, en las profundidades cognitivas del discurso que asen las personas hablantes de grupos poderosos.

Estas personas hablantes no solo desearán controlar un conocimiento en específico y sus opiniones representadas en modelos mentales subjetivos de determinadas personas "recipientes": también estará en su lista de deseos el conocimiento en general, las actitudes e ideologías compartidas por grupos enteros o personas ciudadanas. Esto será posible por conducto del control de determinadas estructuras argumentativas como editoriales de medios de comunicación influyentes o discursos políticos.

Esas prácticas dominantes condicionarán los modelos mentales de los grupos sociales vulnerables para trazar una directriz firme hacia una red de ideología o

conocimiento en concreto y de interés del grupo dominante (Forest, 2009). Esta "guerra de influencias" puede tratar sobre conceptos también interesantes para el grupo —llamémoslo— recipiente, como en casos relacionados con la educación, pero sobre todo, como he destacado anteriormente, de interés por parte del grupo dominante *contra* el grupo recipiente, llegando incluso a casos extremos de manipulación o adoctrinamiento (Winn, 2000).

El control discursivo de modelos situacionales específicos y de representaciones sociales compartidas —en forma de conocimiento sociocultural adquirido—, además de actitudes de grupo e ideologías, depende no solamente de estrategias persuasivas desdobladas tanto en el texto como en el habla, sino también en las condiciones que se den en el contexto. Estas condiciones serán el caldo de cultivo que impulse a los grupos recipientes a aceptar toda la nube ideológica que nublará sus mentes, mediante el concepto de legitimización ya mencionado anteriormente en el epígrafe b) del Bloque I (Nesler et al., 1993). Y estos grupos recipientes, en el común de los casos, carecerán del conocimiento necesario para desafiar el oscuro discurso al que se encuentren expuestos (Wodak, 1987).

Muchos de los recursos discursivos vilipendian la forma en que los grupos recipientes asimilan el vertido dominante y modulan sus modelos mentales, llegando a asumir como norma comportamientos estereotipados o prejuicios (Levy, 2009; Tajfel & Forgas, 2000).

En la **Figura 4** queda reflejado el mecanismo que sigue la reproducción del poder y dominación a través del vínculo entre estructuras sociales, comunicativas y cognitivas; cómo el control se encadena mediante la influencia sobre eventos comunicativos y, de forma indirecta, la influencia sobre los

modelos mentales individuales y grupales, moldeando actitudes, ideología y conocimiento.

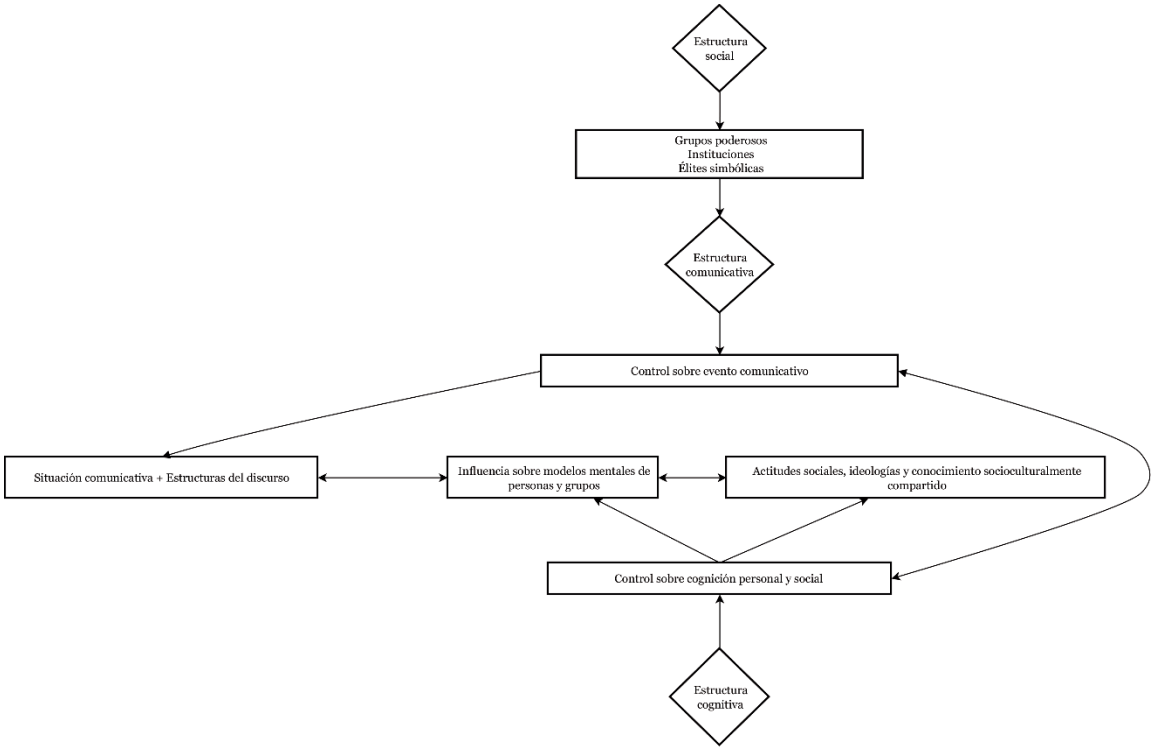

Figura 4. Mecanismo de reproducción y poder a través del vínculo entre estructuras sociales, comunicativas y cognitivas. Elaboración propia.

Figura 4. Mecanismo de reproducción y poder a través del vínculo entre estructuras sociales, comunicativas y cognitivas. Elaboración propia.

En definitiva, una cognición socio-personal sesgada puede controlar las acciones sociales que sean consistentes con los intereses de los grupos poderosos y de las élites simbólicas, cerrando el círculo discursivo del poder, dominación y control mental.

Capítulo II: Aproximación al Género como categoría determinante en el Discurso

Un elemento que consideré enriquecedor para incorporar en mi aproximación a los ECD fue el constructo sociocultural de género. Más concretamente, fue introducido como categoría de estudio en la tercera[4] producción científica de mi Tesis Doctoral (Bloque V - III).

El estudio del discurso y el género ya ha sido una empresa previamente realizada por personas académicas en lingüística, antropología, psicología social y demás disciplinas. El corazón de los estudios sobre género y discurso late, por un lado, en los recursos lingüísticos que la persona hablante emplea presentando, así, la dimensión de género como un plano más de su existencia en relación con otros planos, dentro de una comunidad categorizada, estando en mayor o menor medida de acuerdo o en desacuerdo con esa categorización; por otro lado, en la construcción discursiva del género y de todos aquellos elementos que lo componen (S. Kendall & Tannen, 2015).

Debido a la complejidad que posee este concepto como fenómeno social, el estudio del género y discurso necesita de una minuciosa atención a la influencia cultural que nuestra sociedad ejerce sobre las formas que *tiene* el género de

[4] Como nota aclaratoria, he de apostillar lo siguiente: por la circunstancia derivada en dicha producción científica de haber tenido como participantes de estudio a enfermeras y pacientes mayores exclusivamente mujeres, me centraré en este capítulo —cuando corresponda— en la relación entre el género femenino y el discurso. De esta manera, el hilo conductor de la presente tesis guardará coherencia entre su parte introductoria y la correspondiente a los hallazgos. Asimismo, declaro desde ya, que el género masculino no queda desterrado en el olvido, pues mi deseo y proyección investigadora futura, dentro de mi área de conocimiento, también incorporará la aplicación de los conocimientos adquiridos, a lo largo de mi trabajo de tesis doctoral sobre los ECD, en la dimensión propia a las masculinidades enmarcada, a su vez, en los cuidados de enfermería.

comunicarse y de negociar, ambas conectadas al poder; y a las múltiples interrelaciones entre género, discurso y significado social.

Sección I: Analizando la relación entre Género y Discurso

Con base en diversos estudios previos, Tannen (Tannen, 1991) expuso que los patrones discursivos asociados al género crean una red sobre cómo mujeres y hombres establecen sus relaciones sociales. Así pues, la autora concluyó que, las estrategias lingüísticas encontradas que caracterizaban los discursos de mujeres y hombres podían ser entendidas como herramientas de interacción social.

Tannen identificó que las estrategias comunicativas desplegadas por mujeres iban encaminadas a una simetría social, esto es, identificar similitudes y casar experiencias personales entre sí (Tannen, 1991). Coates (Coates, 2013; Jennifer, 1996), por su parte, corroboró lo expuesto por Tannen mediante el denominado "reflejo" lingüístico, conseguido a través del uso de paralelismos sintácticos y de palabras y oraciones clave.

Durante la década de los noventa, numerosas personas académicas clasificaron este acercamiento de género en la investigación en dos tipos distintos (Henley & Kramarae, 1991): una aproximación en términos de poder o dominación, que se encauzaba hacia la desigualdad social como desencadenante de patrones de género en el uso del lenguaje, o una aproximación en términos de cultura o diferencia social, que se encaminaba hacia una socialización segregada por sexos como la fuente de esas mismas diferencias.

Este doble entendimiento de la investigación del discurso y género venía doblemente marcado por vertientes bien diferenciadas. Mientras que el término "dominación" lo aportaba el campo de la comunicación y sociología, el término "diferencia" venía incorporado de la antropología o la lingüística (Maltz & Borker, 1998; Tannen, 1991). No obstante, una aproximación equilibrada entre ambas

visiones apuntaría los aspectos esenciales del género y su consecuente comprensión, de forma que poder, dominación y diferencia social sean conceptos no excluyentes, sino inclusivos en su estudio (Eckert & McConnell-Ginet, 2013). De hecho, un compromiso con la injusticia social, la desigualdad y, por ende, las diferencias sociales es un potente combustible para unos ECD que son el látigo que azota la brecha del desequilibrio de poder.

Como otra capa más en el plumaje de la inextricable relación entre diferencia social y dominación en género y discurso es el análisis de la comunicación en los entornos laborales (Tannen, 1994), donde se demuestra que las estrategias discursivas manejadas por aquellas personas en posición de autoridad no son únicamente formas de ejercitar poder, sino formas de balancear las necesidades, tan potencialmente conflictivas como imperantes, de mantener o alcanzar un estatus y notoriedad. Según Goffman (Goffman, 1977), esta noción está ligada a la clase de sexos —entendiendo el término clase según la Teoría de los Tipos Lógicos de Bertrand Russell: como parte de una misma colección (Fernández, 2008).

Otra perspectiva teórica provista por Ochs (Elinor et al., 1992), sin embargo, argumenta que las formas —llamémoslas, por ejemplo— *generizadas* de habla no expresan directamente género sino que, más bien, lo "indexan" mediante la creación de posturas o actitudes asociadas culturalmente a mujeres u hombres (o volviendo a Goffman, a clases de mujeres o a clases de hombres).
En otras palabras, podríamos decir que, desde esta perspectiva, la relación entre discurso y género queda intercedida de manera indirecta y concomitante: el componente lingüístico se encarga de comunicar directamente mediante el ejercicio del habla en determinados contextos, y de manera simultánea, contribuye a crear actitudes ligadas a ese momento.

La actuación de este proceso se desenvuelve de tal forma que la *indexación* de esas actitudes provoca un encaje en expectativas socioculturales y creencias ligadas al género que, como consecuencia, permite el surgimiento de una identidad de género en la persona hablante. No obstante, las actitudes generadas individualmente no serán análogas siempre, pues en función del contexto (por ejemplo, ya sea en el hogar o en el trabajo), las personas hablantes se dirigirán en su entorno a otras personas de manera distinta o adaptada, tal y como demostraron varios estudios como el análisis etnográfico de Kendall (S. E. Kendall, 1999).

La existencia de estos estudios apoya el vínculo entre el habla, las prácticas discursivas y los significados sociales con horizonte en el género, que prosperan desde una práctica basada en la comunidad, algo que Eckert & McConnell-Ginet (Eckert & McConnell-Ginet, 1992) circunscribieron —el término comunidad— como grupos de personas que se dan encuentro con el ánimo de involucrarse mutuamente en una actividad o empresa. Las autoras argumentaron que las prácticas lingüísticas y sus significados sociales emergieron de esas comunidades a lo largo y ancho de las maneras que tienen de hacer las cosas, de hablar, de creer y la forma en que las relaciones de poder reflotan durante el curso natural de la empresa.

De manera extensiva a su trabajo anterior, las autoras incitaron a las personas académicas estudiosas sobre el género y el discurso a extender su campo de visión hacia una localización de prácticas comunitarias que se relacionasen con el mundo exterior: con otras comunidades diferentes, redes sociales, instituciones y otros colectivos globales (Eckert & McConnell-Ginet, 2007).

El paradigma socio-constructivista ha prevalecido en las investigaciones sobre discurso y género. Las personas académicas actualmente concuerdan en

esa conceptualización del género y los comportamientos asociados a este —desarrollados mediante procesos sociohistóricos—, así como en las identidades de género a las que se ha llegado mediante la interacción de citados elementos. Esta germinación de comportamientos *generizados* han sido denominados formas de "desplegar", "demostrar" o "hacer" género, algo en lo que la Teoría Performativa de Género de Butler ha sido gratamente influente (Butler, 2004). Sin embargo, la relación entre el género y el discurso es ahí más que nunca manifiesta, pues, ¿qué mejor manera de desplegar, demostrar, o hacer algo, que comunicándolo?

Capítulo III: Aproximación a la Cultura en los Estudios Críticos del Discurso

Tal y como aconteció en el Capítulo II del presente Bloque II, nuevamente me vi en una coyuntura que me estimuló a recoger el testigo de otro elemento analítico en mis ECD: la cultura. Más concretamente, fue incorporada como elemento de análisis en la cuarta[5] y última producción científica de mi Tesis Doctoral (Bloque V - IV).

La conexión directa entre cultura y discurso ha sido algo que no ha recibido tanta atención como otros miramientos en los ECD. Un área que ha sufrido esa falta de crianza dentro de los ECD es la Aproximación Cultural (ACECD) a los mismos.

La ACECD se presenta no solo como un marco teórico sobre el que acomodar nuestra mirada investigadora, sino como una herramienta analítica que pueda ser utilizada para escudriñar el componente cultural latente en el discurso (Gavriely-Nuri, 2017). Digámoslo de otra manera, la ACECD expondrá y examinará las formas en las que los códigos culturales calan en el discurso, y contribuyen a la reproducción desigualitaria del poder (Gavriely-Nuri, 2015).

En consonancia con el comienzo de este párrafo, la conexión entre cultura y discurso se encuentra relativamente poco desarrollada en el amplio abanico de posibilidades teórico-críticas que nos ofrecen los ECD. La causa de este infradesarrollo puede deberse quizá a la compleja y etérea naturaleza del concepto de "cultura", o quizá simplemente porque la inmensa mayoría de las

[5] Dicha producción científica tuvo como epicentro de análisis las relaciones de poder establecidas entre enfermeras migrantes españolas y personas mayores noruegas, en el contexto de una atención domiciliaria de enfermería. Para mayor detalle, ver la Producción IV, correspondiente al Bloque V.

personas investigadoras de los ECD pertenecen al campo de la lingüística, en lugar del campo de los Estudios Culturales (EC). En cualquier caso, se podría concebir a la ACECD como una rama de los ECD que profundiza y navega por los grandiosos mares de la cultura, los códigos culturales, las narrativas discursivas y el ACD.

Será interesante plantearse cómo la cultura se presenta como un elemento clave en la construcción del discurso de las personas hablantes, y cómo el ACECD podría responder a esa construcción. Por supuesto, no podemos soslayar que la propia cultura es un elemento integral de los ECD: la cuestión aquí es que ahora, debe ser explicitada o problematizada en el ojo del huracán de los ECD (Carbaugh, 2007).

Sección I: Descubriendo los principios teórico-metodológicos de la Aproximación Cultural a los Estudios Críticos del Discurso.

Si la ACECD se focaliza en los aspectos culturales de cualquier texto, ya sea oral o escrito, debe cumplir con unos principios acordes a la naturaleza de esta aproximación. Estos principios, son los siguientes (Gavriely-Nuri, 2017):

1. Ningún texto escapa del contexto cultural en el que se desarrolle.
2. Más que la deconstrucción de estructuras lingüísticas, la ACECD debe ir encaminada a destapar los elementos culturales y transculturales inmersas en el discurso de las personas hablantes.
3. La ACECD emplea herramientas y nociones metodológicas traídas de los EC.
4. La perspectiva investigadora multi o transcultural facilita la identificación de elementos únicos subyacentes en códigos culturales y, por tanto, contribuye positivamente en el proceso de descodificación de los mismos.
5. Descodificar códigos culturales exige no solo una familiaridad íntima con el lenguaje de una comunidad, su cultura e historia, sino una especial conciencia de la idea de que la creación social e histórica debe ser contemplada como "un evento natural o como un resultado inevitable de características naturales" (Thompson, 1991).

6. La ACECD demuestra que, cuanto más lejos se propague la retórica del poder, menor diferencia habrá entre grandes y pequeñas comunidades culturales.
7. La ACECD persigue la confección de un "diccionario global" de poder y manipulación. Para *añadir* entradas a este diccionario, detecta, entre otros recursos discursivos, el uso de metáforas y modismos.
8. La ACECD analiza prácticas verbales y no verbales, porque no solo se limita al estudio de estructuras lingüísticas del discurso.
9. La ACECD analiza tanto discursos reales como ficticios. Esto se basa en la asunción de que una historia ficticia puede tener la misma habilidad que una historia de vida para actuar como repositorio de códigos culturales, y así contribuir a la desigual reproducción del poder y el abuso del mismo.

Capítulo IV: Pragmática, Retórica y Argumentación

Una vez descubiertas mis cartas teórico-metodológicas sobre la mesa de mi Tesis Doctoral, ahora habré de explicar cómo realicé la jugada analítica con esta mano.

A lo largo de mi trabajo durante la presente Tesis, me he familiarizado con varias metodologías de investigación, distintas[6], algunas; afines a los ECD, ante todo, otras. Sin embargo, todo el trabajo realizado queda abrochado bajo el cinturón de la aproximación sociocognitiva a los ECD (V. Dijk, 2015), cual cascada que humedece todo hallazgo salpicado por ella.

Sin embargo, ¿cómo he remangado mi prenda analítica de vestir para satisfacer los inminentes objetivos de mi Tesis Doctoral? Por supuesto, el análisis lingüístico de los subniveles del discurso me ha servido como guía para desempeñar un ACD, dentro de los cuales podemos encontrar, por ejemplo, los niveles sintáctico y semántico. No obstante, tuve especial predilección por los niveles pragmático-retórico-estilísticos, además de una aguda inclinación por la argumentación de las personas hablantes, pues desde la óptica sociocognitiva de los ECD, serán las herramientas que me permitan tunelar los enredos de los discursos argüidos entre grupos sociales. Sea, pues, una ventana que se abra a la

[6] Haciendo referencia a uno de los criterios de rigor y calidad en la Investigación Cualitativa —triangulación de técnicas y metodologías de investigación— comentado previamente en el Bloque I, Capítulo III, además de centrarse mi investigación en los ECD, he realizado investigaciones complementarias para responder los objetivos de la presente tesis, con metodologías como la fenomenología hermenéutica, o la meta-síntesis de estudios cualitativos primarios (para mayor detalle, ver Bloque IV).

paleta de pintura analítica que se ha empleado en mi —en honor al título de la presente tesis— aproximación desde el análisis crítico del discurso.

Sección I: Acercamiento a la Pragmática Cognitiva

A pesar de que existe cierta crítica que pretende subrayar el carácter individualista de la pragmática, y resaltarla como una aproximación que no tiene en cuenta el componente contextual del discurso de manera suficiente (Fairclough, 2001), también es una herramienta teórico-metodológica valiosa en los ECD.

Con el pretexto de evitar esa aparente desconexión del contexto, la entrada en escena de acercamientos cognitivos a la pragmática, como la LCg, facilita la manera de operacionalizar el examen de la interfaz entre discurso, sociedad y cognición (T. A. van Dijk, 2006; Van Dijk, 2008).

En términos generales, la dimensión —dentro de la pragmática— de la Pragmática Cognitiva (PC) otorga el potencial de detectar el efecto que tiene el contexto en el discurso, y el discurso en el contexto, mediado a su vez por la cognición de las personas hablantes durante la práctica social que representa el uso del lenguaje.

Aunque la pragmática no sea el epicentro de un análisis llevado a cabo por las personas analistas críticas del discurso, es hartamente difícil encontrar alguna pieza de discurso que no incluya parámetros pragmáticos como los actos de habla, implicaturas o presuposiciones, sensibles a la inferencia (O'Halloran, 2019; Sperber & Wilson, 1986). Así, la PC pone el énfasis de su orientación en la ideología velada que codifica el discurso, y que lo hace interpretable, como en casos relativos a los aspectos ideológicos que configuran los actos de habla (Fairclough, 2001; T. A. van Dijk, 2006).

Según la Teoría de los Actos de Habla, estos no solo son necesarios para describir el mundo social que nos rodea, sino para realizar una acción determinada siendo la unidad básica de información, pues, los mismos actos de habla (Searle et al., 1980).

Con relación al estudio del discurso indirecto y el uso estratégico del mismo, Chilton destaca sobremanera los conceptos pragmáticos de implicatura[7] y presuposición en el análisis del discurso político (Chilton, 2004). Por su parte, Wodak también aplica fuertemente los principios pragmáticos en su AHD (Wodak, 2007). Por consiguiente, y teniendo en cuenta el largo etcétera que seguiría a las personas autoras citadas anteriormente, un gran número de personas afines a los ECD utilizan la pragmática como herramienta suplementaria en los rigurosos análisis sociales. Yendo más allá, y acogiéndonos a la PC, podremos introducirnos en los procesos *hacedores* de significado sociocognitivo, en la lucha contra el abuso de poder y el desafío hacia las legitimadas —a la par que socialmente aceptadas— desigualdades sociales reproducidas por un discurso menos evidente, más hermético; que emplee premisas, connotaciones o asociaciones ambiguas (Polyzou, 2017). En definitiva, representaciones mentales compartidas que se basen en determinadas presuposiciones ideológicas.

[7] La implicatura podría definirse como la parte del significado de un acto de habla que es determinado no de forma explícita y semántica, sino pragmática, siendo su naturaleza interpretativa, implícita e ideológica (Recanati, 1989).

Sección II: El Arte y Ciencia de esgrimir la Palabra: Estrategias Retóricas y Argumentativas en la Investigación Crítica

La retórica. Aquella disciplina ya establecida por Aristóteles, cuyas obras son consideradas por la historia como hitos del pensamiento humano.

Aunque la retórica se desdobló puntualmente al paso del tiempo en la estilística, Aristóteles mantuvo su concepción del arte —o "téchne"— de la retórica como una teoría de la argumentación (Aristóteles, 2022). Aristóteles describió a la retórica como la contraparte de la dialéctica. Mientras que la dialéctica se corresponde con el arte filosófico de mantener una tesis en una conversación sin contradicción alguna, la retórica fue definida como "una habilidad, en cada caso particular, para detectar los medios a nuestro alcance posibles para persuadir" (Aristotle, 1991).

Será responsabilidad de las personas analistas críticas del discurso la de desvelar el engaño, la persuasión. Para ello, serán, pues, necesarias ciertas herramientas que nos sean de utilidad en el momento de adentrarse en la cortina de humo que representa el atolladero del discurso (Kienpointner, 2017).

¿Cuál será la herramienta por antonomasia para los ECD? El cuestionamiento crítico, o dicho de otra manera, la mera actitud crítica que ponga en duda todo medio empleado para la persuasión de la persona hablante que esgrima el discurso.

Una de las estrategias retóricas más importantes es la del Argumento Pragmático (AP). El AP es una especie de argumentación causal que evalúa las decisiones tomadas, iniciativas y actividades positiva o negativamente, en función

del efecto que desencadenen (Kienpointner, 1992; Walton et al., 2008). Por tanto, la representación de los AP puede ser tanto positiva como negativa.

Veamos un caso de AP positiva junto a un posible cuestionamiento crítico en la **Figura 5**, tomando como ejemplo una situación en la que una paciente mayor comunica que las enfermeras la hacen sentirse joven mediante su trato. Este ejemplo, por cierto, ha sido extraído directamente de la primera producción científica de mi Tesis Doctoral, perteneciente al Bloque IV de resultados.

Otra gran baza de la retórica es la figura de la metáfora. Esta figura retórica tiene un impacto cognitivo ya reconocido desde Aristóteles (Aristóteles, 2022) y destacado por otras personas autoras contemporáneas (Lakoff & Johnson, 1980; Ricoeur, 2013). Las metáforas, poderosas herramientas literarias y visuales, pueden moldear nuestra percepción de la realidad e incluso cambiar nuestra forma de verla. Por este motivo, no pueden ser vistas como meros ornamentos del discurso, sino como componentes de gran valor argumentativo (Kienpointner, 2017).

También destacan técnicas argumentativas explícitamente diseñadas para la persuasión, como la concesión aparente, herramienta retórica mediante la cual la persona hablante enmascara el rechazo en su modelo semántico sobre algo en particular, aportando una declaración en favor de ese algo, seguida de otra sutilmente discordante (Teun, 1999)

En definitiva, las figuras retóricas del discurso —entre las que se encuentra la metáfora— tales como la metonimia, la hipérbole, la ironía o las preguntas retóricas (Kienpointner, 2017), poseen una magnificente y majestuosa fuerza, que como lava candente que arrasa campos de palabra, buscan hacer mella en la naturaleza sociocognitiva de las personas hablantes involucradas en el discurso.

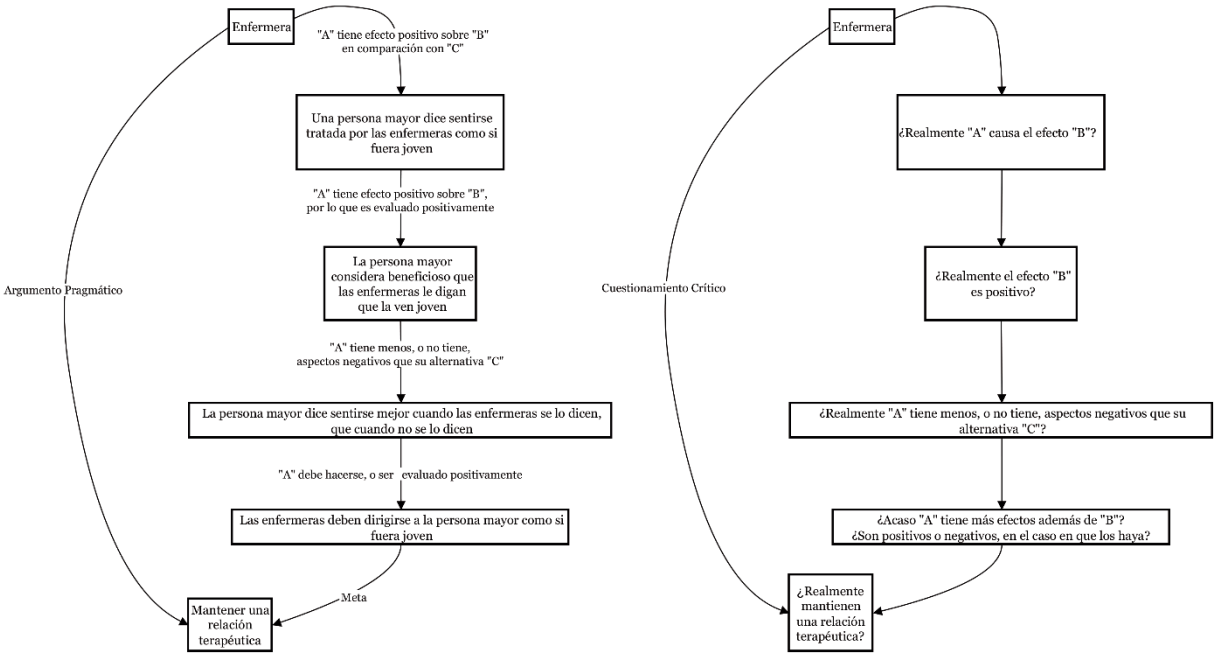

Figura 5. Ejemplo de AP positiva proveniente de mis estudios de tesis. Elaboración propia.

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Bloque III Atención de Enfermería, Discurso y Envejecimiento

La matriz de mi Tesis Doctoral es la fascinante relación entre tres elementos en la esfera del cuidado: personal de enfermería, discurso y personas mayores.

¿Qué caracteriza —y categoriza— el discurso de las personas mayores que viven solas en su domicilio con relación a los cuidados de enfermería que reciben en su propio hogar? ¿Y el de las y los profesionales de enfermería que atienden a esas personas mayores? ¿En qué medida el discurso del personal de enfermería influencia el uso de los servicios sanitarios de estas personas mayores que viven solas? ¿Cómo hacen acto de presencia, se interrelacionan e influencian los procesos de toma de decisiones compartida, escucha activa de preferencias o, en definitiva, la participación en los cuidados de enfermería, en el discurso de las personas mayores y el personal de enfermería de atención primaria? ¿Qué representaciones sociales proyectan ambos grupos sociales? ¿Qué entraña el discurso de ambos grupos sociales desde un punto de vista cognitivo? ¿Qué repercusión tienen todos estos elementos en las relaciones de poder que los conecta?

Estas son gran parte de las preguntas que me arrojaron a la palestra de los ECD. Pero no olvidemos: los ECD son la puerta al verdadero esqueleto de la presente tesis, que no es otro que la relación establecida entre profesionales de enfermería y personas mayores que vivan solas en el ámbito comunitario. Que así sea, pues; que los ECD sirvan como pivote para discernir qué realidad social y cognitiva mece la cuna de los cuidados enfermeros en personas mayores.

Capítulo I: Discurso y Atención de Enfermería

Sección I: Comunicación en la Salud como eje de los Cuidados de Enfermería

Unos cuidados de enfermería de calidad podrían definirse como aquellas intervenciones enfermeras dirigidas hacia una atención autónoma y colaborativa de las y los pacientes, con el propósito de satisfacer sus necesidades humanas a través de una atención empática, respetuosa, responsable y defensora de sus derechos, ya sean personas sanas o enfermas, y siempre desde una perspectiva biopsicosocial (Burhans & Alligood, 2010; *Enfermería - OPS/OMS | Organización Panamericana de la Salud*, n.d.; Papathanasiou et al., 2013).

Los cuidados de enfermería se fundamentan, desde su definición, en la comunicación y relación que se establece entre el personal de enfermería y las o los pacientes ya que, si la práctica enfermera cubre sus necesidades, tenemos a la comunicación como pieza esencial del puzle de los cuidados para comprender dichas necesidades y actuar así en base a ese entendimiento (Smith, 2019).

Para abordar la noción del discurso e incorporarla a la atención de enfermería, me guiaré por la definición que Candlin et al. (Candlin et al., 2008; Sarangi & Roberts, 2008) hace del mismo, como toda aquella información contextualmente sensible derivada de un uso del lenguaje, ya sea escrito o hablado, producido como parte de una interacción entre personas hablantes y oyentes, escritoras y lectoras. De esa manera, me alejo de la concepción discursiva como una identificación meramente estructural en términos de relaciones y prácticas institucionales, y abrazo la idea de discurso como una herramienta lingüístico-

social, que concibe al lenguaje como un aparejo que contribuye activamente en la construcción y constitución de dichas relaciones y prácticas (Candlin et al., 2008).

Con respecto a la atención enfermera y la comunicación en los cuidados, el discurso juega un papel más que notable en la constitución de prácticas que tienen lugar en el entorno sanitario, siendo una intervención en sí misma en un contexto de los cuidados de enfermería, con el objetivo de lograr resultados beneficiosos para la salud de las y los pacientes, además de conseguir una óptima satisfacción percibida sobre dichos resultados y cuidados.

En el terreno de la comunicación en los cuidados, los géneros discursivos abarcan desde relatos personales concernientes a procesos de salud y enfermedad, como encuentros traducidos en conversaciones entre pacientes y profesionales de enfermería, hasta documentación sanitaria o incluso información presentada en el prospecto de los medicamentos. No obstante, y al mismo tiempo que la ingente variedad de géneros discursivos diluvia sobre el paraguas de la comunicación en los cuidados, son los propios cuidados de enfermería los que están constantemente evolucionando en un flujo concomitante y es, a través del discurso, que es posible apreciar con exactitud qué cambios están aconteciendo y hacia dónde se dirigen (Harvey & Adolphs, 2012).

Un caso que serviría para ilustrar esto, serían las últimas décadas que han servido de testigo de los profundos cambios que ha sufrido la política de cuidados y su práctica, teóricamente ahora orientados a empoderar el rol de las y los pacientes en los cuidados, y a conseguir una atención centrada en la y el paciente (Brian et al., 2006). Estos cambios se ven reflejados, desde otro prisma, en el uso de determinadas prácticas discursivas, como por ejemplo en la sustitución del término tradicional “paciente” en determinados contextos situacionales

sanitarios por el de "cliente", con un matiz que refleja la esencia consumista y de —supuesta— libertad proveniente de ideologías occidentales.

La existencia de aproximaciones al cuidado que enfatizan la autonomía de la y el paciente —o cliente— en procesos como el de Toma de Decisiones Compartida (TDC), conlleva que el personal sanitario emplee, en sus numerosos momentos de valoración o entrevista con las y los pacientes, una serie de preguntas de respuesta abierta que permitan a las y los pacientes desarrollar su discurso y tomar la iniciativa en la proposición del tema principal del mismo, de forma que —moralmente— las personas proveedoras del cuidado se ven impelidas a mostrar empatía y ejercitar una escucha activa hacia sus clientes (Babul-Hirji et al., 2010; Fairclough, 2013).

Por ende, los cuidados contemporáneos pueden ser vistos como un movimiento cismático del modelo paternalista de atención sanitaria —en el cual la persona profesional sanitaria se sitúa como la principal responsable de la salud de las y los pacientes— que se encamina a una práctica de cuidados centrados en las y los pacientes, incorporándolas en los procesos de TDC. Este cambio también puede apreciarse en la forma en que la comunicación hace acto de presencia en los entornos sanitarios.

Cualesquiera que sean las modificaciones que afecten a la práctica enfermera contemporánea, siempre influirán en la comunicación de sus participantes, debido a la inevitable naturaleza de los cuidados. Tal y como apunta Sarangi (*Editorial*, 2004), un encuentro clínico entre profesionales de la salud y pacientes es, de facto, una relación comunicativa que se establece entre dicho binomio. La comunicación es la insignia de cualquier provisión de cuidados de enfermería, especialmente, en términos de cómo el discurso en contextos sanitarios es causa,

y a la vez consecuencia, de la adopción o modificación de determinados comportamientos de salud.

Gran parte de la investigación cualitativa coetánea a nuestro tiempo se focaliza en la voz y perspectiva vital de las y los pacientes: en su narrativa personal de las experiencias ante situaciones de salud y enfermedad. Dicha investigación prioriza el rol del discurso de las y los pacientes sobre sus historias personales relacionadas con la salud, explorando el significado que discursivamente las personas articulan y contextualizan desde su condición de paciente. La investigación —en términos generales— sobre la comunicación en la salud ha atraído la atención de numerosas disciplinas como la ética, la psicología, las ciencias sociales, la antropología o la lingüística. Sin embargo, cada vez más se extienden aquellos estudios que diversifican su indagación en cuestiones más allá de la interacción médico-paciente, como pueden ser las prácticas discursivas de profesionales de enfermería (Crawford et al., 1998).

Desde el punto de vista metodológico, la mayor parte de las investigaciones sobre discurso y cuidados se han desarrollado desde un prisma lingüístico, llevando a cabo análisis conversacionales, análisis de textos o aproximaciones desde los ECD. Estas perspectivas han conferido resultados prometedores para reflexionar sobre la actuación del personal sanitario. Incluso, se pueden hallar combinaciones entre varios de estos acercamientos que, con un eclecticismo teórico, tratan de comprender más profundamente las entretelas de la compleja comunicación humana (Jeffries, 2000).

En los últimos tiempos, las personas investigadoras en este campo, ávidas de conocimiento, están trabajando con ímpetu tanto en la crítica y la búsqueda del cambio de determinadas prácticas mejorables en entornos sanitarios, como en su

descripción y, por ende, en alcanzar un entendimiento de las mismas (Francis & Kramer-Dahl, 2004; McHoul & Rapley, 2002).

A lo largo de esta veda que se ha abierto ante los ECD, lo que distingue una perspectiva analítico-crítica del discurso de otras en el campo de la salud, es su determinación sobre la importancia del uso del lenguaje como medio para llevar a cabo determinadas acciones de índole social con una consecuencia en las relaciones de poder (Fairclough, 2013). Su núcleo de estudio residirá, en tales circunstancias, en los dominios de una salud que está plenamente relacionada con el discurso y la acción: la intervención que el personal sanitario realice será condicionada por la interacción directa con las y los pacientes en términos textuales (mediante registros de enfermería o diagnósticos). Entonces, el personal sanitario hará uso de esos textos —de manera síncrona junto a las y los pacientes— para valorar posibles acciones, como tratamientos o prescripciones (R. H. Jones, 2015).

De forma similar, la tarea central de las personas proveedoras de cuidados, en términos del discurso, es determinar qué tipos de intervenciones discursivas están encaminadas a ofrecer resultados beneficiosos para mejorar la salud o mantenerla en personas usuarias del sistema sanitario (R. Jones, 2013). Así pues —y si permanece en nuestro inventario mental el empleo del discurso como forma de acción social—, el AD y su aleación de repertorios analíticos, son de una utilidad manifiesta para asesorar a las personas investigadoras y personal del ámbito de la salud y el cuidado, en la tarea de comprender no solo cómo las personas *fabrican* significado sobre su salud, sino además, cómo *fabrican* salud a lo largo de su discurso diario (Paugh & Izquierdo, 2009).

Tal y como hemos ido deshojando, y en términos de ese significado, la comunicación en la salud interseca lo que Treichler (Treichler, 1987) denomina

"multiplicidad de significados, historias y discursos". Pues, en el nivel más básico, en la visita de una o un paciente a una persona facultativa médica, ya tenemos una interacción entre la "voz de la medicina" y la "voz del mundo vital" (Mishler, 1984). En un nivel más complejo, cada vez que un grupo de personas en un entorno sanitario realiza un acto de habla sobre la salud, de forma inevitable, hace gala de un repertorio de diferentes "voces" como podrían ser la voz personal, la voz profesional, la voz familiar, la voz sentimental, o la voz de un modelo tradicional de salud o cultura. Y todas ellas, identidades, en cierta forma, se dan encuentro en el discurso cual rayo de luz que atraviesa un momentáneo lapso de tiempo.

Sección II: Sobre la importancia del Encuentro Clínico en la génesis del Discurso en Salud

De todos los trabajos realizados por personas analistas del discurso hasta la fecha, la inmensa mayoría —dentro del campo de la comunicación en entornos de la salud— tienen como médula todo aquello que engloba la relación comunicativa entre personal sanitario-paciente. Así, el gran motivo de estudio es comprender cómo las singularidades del discurso y su interacción entre personas en un contexto sanitario afectan la consecución de determinadas metas.

Es en estos encuentros clínicos donde la aproximación que más se ha encargado de estudiar esta circunstancia, el análisis conversacional, donde existe un empeño por entender el proceder lógico de las interacciones que se den durante dichos encuentros, y cómo se van desarrollando, momento a momento, las identidades sociales de personal sanitario (enfermera o enfermero, en el caso que nos ocupa), de paciente (paciente mayor de nacionalidad española o noruega, como veremos más adelante en el Bloque V), y las acciones socio-sanitarias como la TDC, la escucha activa de preferencias o la participación en los cuidados (Garfinkel, 1991; Heritage & Maynard, 2006).

Desde la sociología médica, y dirigiendo nuestra mirada a los ECD, la aparición del desequilibrio de poder en los encuentros clínicos es una consecuencia de una danza entre roles sociales y estructuras institucionales. Por su parte, desde los EC críticos se percibe como resultado del carácter disciplinario inherente al discurso biomédico.

La asimetría en las relaciones de poder en los encuentros clínicos, no obstante, no es solo una cuestión de la que podamos responsabilizar exclusivamente al comportamiento discursivo del personal sanitario. Tal y como se ha comprobado otrora en diversos estudios, las y los pacientes también son proclives en determinadas ocasiones a contribuir al desajuste asimétrico del poder que, como un metrónomo, sigue un compás pérfido y constante inclinando la balanza fuera del punto medio donde se haya la virtud (Have, 1995; Heath, 1992; Silverman, 1987). Específicamente, las y los pacientes han desarrollado circunstancialmente sus propias estrategias para tomar el control interaccional en los encuentros clínicos mediante una formulación de preguntas indirectas sobre temas de salud (West, 1984), o el uso de otras estrategias discursivas sucintas y encubiertas, con el objetivo de tomar control sobre el curso de la conversación y los temas que salgan a relucir, para aplacar las intervenciones sanitarias (Ten Have, 1989).

Será en estos contados casos en los que sobre los hombros del personal sanitario recaiga la tarea de adoptar un rol sutilmente melifluo para tener éxito en el encuentro. Ante esta necesidad, Beck y Ragan demostraron (Beck & Ragan, 1992) cómo el personal de enfermería transitaba discursivamente entre un momento de valoración enfermera y un momento de conversación relajada como método para evadir a las y los pacientes de la sensación de pudor asociada a un examen pélvico. Por otro lado, Coupland et al. (J. Coupland et al., 1994) destacaron la forma en que el personal facultativo médico y pacientes mayores trabajaban juntos mezclando momentos de interacción médica con otros de corte social, de modo que fuera posible lograr un ambiente “menos clínico” durante el encuentro. Asimismo, Adolphs et al. (Adolphs et al., 2007) enunciaron en su estudio cómo las enfermeras reformulaban sus pesquisas sobre cuestiones de

riesgo como un trámite administrativo, en lugar de hacerlas pasar por interrogatorios médicos.

La clave de toda la complejidad de los encuentros clínicos radica en entender que la gestión de esos momentos apenas se consigue de forma plana y linear, sino que las personas participantes de dichos encuentros manejan normalmente modelos mentales dinámicos y múltiples acontecimientos que ocurren al mismo tiempo, algunos de los cuales pueden conllevar cierta ambigüedad o ser susceptibles de ser inferidos distintamente entre las personas hablantes durante la interacción. Por ello, un AD conocedor de esta trabazón comunicativa, y un ACD que integre esta marea de elementos cruciales para la detección de un desequilibrio en las relaciones de poder, se torna imprescindible para cualquier persona analista crítica del discurso en la salud y, en nuestro caso, el envejecimiento.

Capítulo II: Discurso y Envejecimiento

Sección I ¿Cuándo comienza la Senectud? Sobre la conceptualización de la Edad Avanzada

A lo largo de su recorrido científico, las investigaciones sobre el campo de la senectud han llegado a cerciorarse de que el concepto de edad es mucho más complejo que un simple número, traspasando las fronteras de una solitaria categorización biológica.

La edad cronológica no es más que una ínfima parte de la forja donde se fragua la edad vital.

El trabajo de Eckert (Eckert, 1984) dio buena cuenta de ello en sus estudios, al encontrar que la edad cronológica no se correlacionaba con los cambios en la actitud lingüística de las personas a medida que cumplían años, algo también identificado en la esfera de las aspiraciones, los roles y la orientación social de las mismas. La autora llegó a argumentar que las personas investigadoras debían, en tal caso, desviar el foco lejos de la edad cronológica, y redirigirlo hacia aquellas experiencias vitales que le den sentido al concepto de edad (Eckert, 1997). Algo más reciente, el estudio de Coupland, que señaló el concepto de cronología como categoría diferenciadora en un sistema de significado encorsetado y socialmente adjudicado, además de declarar que el envejecimiento biológico es tan solo una de las métricas que imponemos sobre nosotros y nosotras mismas, a la par que sobre otros y otras (J. Coupland, 2009).

Las personas normalmente se sienten mayores o jóvenes con respecto a su edad cronológica (Boden & Bielby, 1986; N. Coupland et al., 1989), y en determinadas ocasiones, esta diferencia entre la autopercepción y el paso real del tiempo puede trazarse sobre el concepto de edad funcional, el cual hace referencia a los paulatinos cambios que sobrevienen en la sensibilidad sensorial de la persona (visual o auditiva, por ejemplo), apariencia, salud física y mental, al mismo tiempo que en el nivel de actividad física (Counts & Counts, 1985). Otro desdoble en la dimensión de la edad comprende la edad social, que hace referencia al número de ocasiones en las que una persona experimenta el mismo "momento" o "rito" social a lo largo de su vida, siendo esta edad mayor cuanto más sea la repetición, y no coincidiendo necesariamente con la edad cronológica (Counts & Counts, 1985).

En la oquedad de las grandes disparidades entre edad percibida y cronológica, reside la extrema variedad a través de los mismos segmentos de población mayor en una sociedad.

Las personas mayores pueden diferir enormemente entre ellas mismas, en términos de salud física, actitudes hacia sí mismas y hacia otras, necesidades comunicativas, memoria, juicio y razonamiento (Jolanki, 2009; Nelson & Dannefer, 1992).

Esta titánica variedad nos dificulta imaginar un uso del lenguaje normativo con respecto a la edad. Hace ya más de tres décadas, diferentes personas autoras argumentaron que —con el objetivo de ser capaz de entender si las personas envejecen de forma sana— se necesitaban una serie de conceptos estandarizados a los que dirigirnos en cada estadio del ciclo vital, para comprobar el proceso de envejecimiento en cada "momento" de vida (Wiemann et al., 1990). Y aun así, a pesar de ello, todavía hoy existen estudios sobre el lenguaje acerca de personas

mayores, en los que se les suele comparar con los estándares comunicativos, sociales y psicológicos de personas de mediana edad.

Tal y como Eckert promulga, tomar el uso del lenguaje de las personas de mediana edad como referencia universal oscurece la singularidad de las maneras de hablar en cualquier etapa de nuestra vida, ya que son parte de una estructura comunitaria lingüística, y los recursos lingüísticos empleados en cualquiera de esas etapas tiene un significado social específico por y para ese momento vital (Eckert, 1997).

Entonces, como ya se ha destacado, no perecen las diferencias sobre la edad en terreno individual de cada uno o una, sino que también pueden existir en la esfera comunitaria. Las circunstancias que envuelven a la persona, su contexto: todo aquello que la hace situarse en *su* mundo también interacciona con ella. Somos un continuo río vital donde numerosos afluentes emanan del mismo: los encuentros, las personas, las experiencias de vida, los cuales nutren y completan, cambian y modifican nuestra percepción de la realidad y, por ende, nuestra autopercepción.

¿Qué ocurriría si la pareja de una persona mayor, en el caso de que la tuviera, dejara este mundo por fallecimiento natural? ¿Y si su red de apoyo social estuviera disminuyendo a medida que sus pares van falleciendo o ingresando en entornos comunitarios de asistencia vital? ¿Le harían sentirse *más vieja*?

¿Es que las personas mayores entablan nuevas relaciones con otras personas pertenecientes a generaciones más jóvenes, o su círculo social es de su generación? ¿Las personas mayores tienen acaso contacto con otras personas que se dirigen a ellas con actitudes teñidas de ideología edadista? ¿Qué pasaría entonces?

¿Afectarían todas estas circunstancias a su autopercepción del proceso de envejecimiento? ¿Repercutirían esas circunstancias en el uso que hicieran de los servicios sanitarios, quizá? ¿Influiría en el discurso durante su envejecimiento?

Sección II: Acercamiento al estudio del Discurso en Personas Mayores

Allá por la década de los años ochenta, cuando los ECD comenzaron a despegar en el panorama científico de la época, la cantidad de investigación vinculada a discurso y envejecimiento no era apenas prolífica, centrando su punto de mira en las generalidades del lenguaje y comunicación en la senectud (Obler & Albert, 1980); en desórdenes y procesos del lenguaje en personas mayores (Beasley & Davis, 1981); en estudios sobre el uso del lenguaje en personas mayores con demencia (Irigaray, 1973); en estudios sobre percepciones discursivas de personas mayores residentes y personal sanitario de una institución para personas enfermas crónicas (R. B. Lubinski, 1976), entre otros.

No fue hasta la década de los años dos mil diez que comenzaron a florecer con fuerza nuevos estudios enfocados en el ámbito que nos ocupa. Algunas personas autoras se dedicaron a describir el lenguaje y/o las habilidades comunicativas durante el proceso de envejecimiento cognitivo, tanto en personas mayores sanas como en otras enfermas de Alzheimer o afasia (Guendouzi & Muller, 2006; Kemper, 2012). Otras, en cambio, relacionaron las elecciones discursivas que las personas hacían durante el uso del lenguaje con un amplio rango de contextos interaccionales y discursivos, en el momento de la construcción de su identidad social como persona mayor o paciente (Hamilton, 1992; Norrick, 2009). Por otro lado, hay personas autoras que reconocieron la vital importancia de las relaciones comunicativas que se establecían a lo largo del periplo vital de las personas mayores, investigando sus actos de habla con personas allegadas, y las interacciones que tenían lugar en instituciones tales como el hogar o las instalaciones sanitarias (R. Lubinski, 2011; Savundranayagam et al., 2007).

Finalmente, hubo quienes examinaron discursos públicos sobre la edad avanzada y el envejecimiento, además del efecto de esos discursos en individuos pertenecientes a todos los espectros de edad (B. H. Davis, 2011; Rozanova, 2010; Yoon & Powell, 2012).

Si consideramos la intrincada naturaleza del concepto de senectud —abordada en el Capítulo I del presente bloque— y la joven "edad" de las investigaciones sobre discurso y envejecimiento, tenemos ante nosotras y nosotros un escenario cuanto menos complicado para gestionar la tarea de seguir el camino marcado por los ECD dentro de esta empresa.

Entonces ¿por qué ceñirse tan solo a una perspectiva para abordar una área de estudio tan escurridiza? Chafe nos ofrece la posibilidad, desde la experiencia de haber discutido datos y metodologías a lo largo de sus estudios relacionados con la lingüística y la mente, de plantearnos que ninguna aproximación metodológica dará respuesta por sí sola ante los interrogantes que nos planteemos, ni será jamás plenamente la correcta (Chafe, 1994). Según su razonamiento, todos los tipos de datos "proveen consideraciones importantes, y todas ellas tienen sus limitaciones" (Chafe, 1994). Así pues, no solo es importante concienciarnos de que ningún acercamiento basado en una sola disciplina de estudio debe monopolizar el paradigma sobre envejecimiento y discurso, sino que la exclusión de algún acercamiento disciplinar distinto conllevaría un más que probable resultado que aportara una comprensión incompleta del fenómeno de estudio.

Encomendarse, pues, a la multidisciplinariedad al mismo tiempo que a la interdisciplinariedad, es comenzar a caminar por la linde del camino. No obstante, me queda por delante una larga y excitante senda que recorrer y, en mi caso, elijo de acompañante la Enfermería

Sección III: Identidad, Edadismo y Relaciones de Poder a través del Discurso en Personas Mayores

Serán nuestras aliadas, tanto para mi acompañante la Enfermería como para mí, las disciplinas de psicología social, sociolingüística o antropología, para limar el interés sobre cómo los patrones y estrategias discursivas de las personas mayores se interrelacionan confluyendo en la construcción de un abanico de identidades en las personas hablantes, a medida que el discurso brota de sus actos de habla.

Normalmente, los estudios del discurso en personas mayores se basan en la utilización del lenguaje de colectivos reducidos en número de participantes mayores en contextos conversacionales, como entrevistas o diálogos espontáneamente surgidos (Hamilton & Hamaguchi, 2015).

La identidad en la tercera edad suele ser examinada como una especie de pacto que llega a un acuerdo en "la intersección entre el dominio público o privado" (J. Coupland, 2009), mediante la conexión de patrones propios de la interacción de discursos en el ámbito de lo privado con evidencia proveniente de discursos de lo público. En ocasiones, estas identidades son variables en función del momento de habla que caracterice el encuentro discursivo, sin tener correspondencia necesariamente con edades cronológicas (Davies & Harré, 1990).

Lo que verdaderamente genera interés sobre el estudio de la construcción sociocognitiva de la identidad en el discurso de personas mayores, es cómo ese pacto, esa negociación de *etiquetaje* tiene lugar en interacciones intergeneracionales, especialmente en contextos institucionales sanitarios y, en

el caso que nos ocupa, donde intervenga el personal de enfermería como en residencias de personas mayores (Backhaus, 2011; Lenchuk & Swain, 2010) o los cuidados de enfermería a domicilio (Heinemann, 2011; Olaison & Cedersund, 2006).

En los entornos sanitarios, pues, cualquier tipo de conducta socio-discursiva ideologizada explícita o silente, de naturaleza edadista o estereotípica desde el personal sanitario (N. Coupland & Coupland, 1998; Martínez-Angulo et al., 2023; Scholl & Sabat, 2008) puede ser exacerbada por limitaciones físicas o psíquicas que sufran las personas mayores (Hamilton, 1996; Sabat† & Harré†, 1992). Por esta misma razón, dichas personas mayores —recipientes de actitudes edadistas— a través de la relación establecida con el personal sanitario, pueden desarrollar una autopercepción y, con ello, una identidad proclive a verse como pacientes antes que personas, o directamente como personas mayores frágiles (Norrick, 2009).

Numerosas investigaciones sobre discurso y senectud en los cuidados de pacientes mayores han destacado los efectos que la despersonalización del discurso tiene, por parte del personal de enfermería hacia personas mayores institucionalizadas, fundamentado en nociones estereotipadas sobre las necesidades comunicativas de las mismas personas mayores (Caporael, 1981; Kemper & Harden, 1999; Ryan et al., 1986; Williams et al., 2009). Dichas conductas *ideologizadas* "inducen sensaciones momentáneas de inutilidad en personas mayores, pero también conducen a la reducción de satisfacción vital y a un declive físico y mental a largo plazo" (Ryan et al., 1986).

Por su parte, Baltes et al. (Baltes & Wahl, 1992) argumentaron que las actitudes edadistas del personal de enfermería en entornos comunitarios de cuidados eran consistentes con el término acuñado por los mismos autores

denominado como “guion de apoyo a la dependencia”. Dicho “guion” lo conformaban determinadas intervenciones de cuidados básicos de enfermería en actividades de la vida diaria de las personas mayores —tales como colaborar con ellas en la vestimenta o la higiene—, en momentos específicos que estaban basadas en su fondo en estereotipos negativos hacia personas de edad avanzada. Dichos estereotipos negativos, sumados al deseo profesional por parte del personal de enfermería de activar su “rol de ayuda”, creaban un comportamiento dependiente en las personas mayores catalogado como “el resultado más probable del contacto social y la atención” facilitada por sus personas cuidadoras (Baltes et al., 1994). Para solventar este tipo de situaciones, diversos estudios ensalzaron el papel del entrenamiento sobre comunicación basada en el discurso para el personal sanitario, con el ánimo de lograr cambios beneficiosos en la relación enfermera o enfermero-paciente mayor en entornos comunitarios de cuidados (B. Davis & Smith, 2011; R. Lubinski, 2011).

Y no es excepción encontrar que, incluso en pacientes mayores que construyen una identidad férrea e independiente, se posicionen como personas débiles o vulnerables en sus interacciones socio-discursivas con otras personas (TAYLOR, 1992; Taylor, 1994).

Será en esos momentos, pues, en los que el personal de enfermería debemos hacer un alto al fuego de nuestra praxis, para cerciorarnos de la importancia e influencia que tiene nuestro discurso sobre la salud holística y la comunicación con las y los pacientes mayores, de manera que sea posible hallar un (re)equilibrio en las relaciones de poder por medio de una manutención y refuerzo de la identidad, autonomía y capacidad discursiva de las personas mayores.

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Bloque IV
Objetivos de la Tesis Doctoral

Capítulo I: Objetivos de la Tesis Doctoral

Objetivo General de la Tesis Doctoral (OG-TD)

1. Analizar las relaciones de poder y dominación en la atención sanitaria a personas mayores en el entorno comunitario.

Objetivos Específicos de la Tesis Doctoral (OE-TD)

1. Identificar y distinguir categorías interpretativas de personas mayores y de profesionales (sistema formal) respecto a la atención sanitaria al mayor.
2. Explorar el proceso por el que estos elementos se conectan, identificando factores influyentes y consecuencias.
3. Describir situaciones de toma de decisiones y participación activa de las personas mayores en la atención.
4. Evaluar si las situaciones anteriores coinciden con situaciones de cuidado sensibles a las preferencias de los mayores.
5. Relacionar los valores hegemónicos entre las personas mayores y el sistema formal de cuidados con los comportamientos profesionales, en términos de respeto del derecho de la persona a elegir y de participación activa en el cuidado.
6. Identificar diferencias culturales que afectan a la interpretación de la situación.

Capítulo II: Objetivos de la Producción Científica de la Tesis Doctoral

Objetivos de la Producción 1 (O-P1)

1. Destacar la experiencia de las personas mayores sobre el uso de los servicios de salud.
   - Correspondencia con: OE-TD1.
2. Descubrir la percepción de las personas mayores usuarias de los servicios de salud sobre el edadismo del personal sanitario.
   - Correspondencia con: OE-TD5.
3. Explorar la relación existente entre el edadismo percibido y la Autopercepción del Proceso de Envejecimiento (APE) de las personas mayores usuarias de los servicios de salud.
   - Correspondencia con: OE-TD2.

Objetivos de la Producción 2 (O-P2)

1. Sintetizar sistemáticamente los resultados de estudios cualitativos primarios sobre cómo las personas mayores que viven en la comunidad experimentan los procesos de TDC, Expresión de Preferencias (EP) y Participación Activa en los Cuidados (PAC).
   - Correspondencia con: OE-TD1; OE-TD3; OE-TD4.
2. Sintetizar qué elementos configuran la aparición de dichos procesos, su interrelación y cómo condicionan las relaciones establecidas entre el personal sanitario y las personas mayores.
   - Correspondencia con: OE-TD2: OE-TD5.

Objetivos de la Producción 3 (O-P3)

1. Analizar críticamente las relaciones de poder entre pacientes mujeres mayores y personal de enfermería de atención primaria.
   - Correspondencia con: OG-TD.
2. Describir las situaciones de Escucha Activa de Preferencias (EAP), TDC y PAC desde el discurso de las pacientes mujeres mayores y personal de enfermería de atención primaria.
   - Correspondencia con: OE-TD1; OE-TD3.
3. Identificar diferencias sobre la percepción de dichas situaciones entre el discurso de las pacientes mujeres mayores y el discurso del personal de enfermería de atención primaria.
   - Correspondencia con: OE-TD4: OE-TD5.
4. Explorar las estrategias discursivas que configuran las representaciones sociales proyectadas por el discurso de las pacientes mujeres mayores y del personal de enfermería de atención primaria.
   - Correspondencia con: OE-TD2.

Objetivos de la Producción 4 (O-P4)

1. Analizar las relaciones de poder a través de la descripción de situaciones de EAP, TDC y PAC entre personas mayores noruegas y enfermeras migrantes españolas en el entorno comunitario.
   - Correspondencia con: OG-TD; OE-TD3; OE-TD4; OE-TD5.
2. Identificar el desequilibrio en la percepción de estas situaciones a través del discurso de las personas mayores noruegas y de las enfermeras migrantes españolas.
   - Correspondencia con: OE-TD1.
3. Explorar el efecto de la experiencia del choque cultural en el cuidado de enfermería a través del discurso de las enfermeras migrantes españolas.
   - Correspondencia con: OE-TD6.
4. Destacar las representaciones sociales transmitidas por las personas mayores noruegas y las enfermeras migrantes españolas moldeadas por medio de las estrategias discursivas empleadas.
   - Correspondencia con: OE-TD2.

Bloque V
Resultados y Producción Científica de la Tesis Doctoral

SÍNTESIS EN ESPAÑOL SOBRE LA PRODUCCIÓN I

Una vez consolidadas las bases teórico-metodológicas de mi Tesis Doctoral, e incrustados en ellas los Objetivos pertinentes, el primer gran reto planteado fue el siguiente:

¿Por dónde empezar a desenmascarar el estado de las relaciones de poder establecidas entre las personas mayores que residen solas en su hogar y el personal sanitario en el entorno comunitario?

Habríamos de empezar por el principio, por la secuencia lógica de acontecimientos que supongan el germen de esta relación *per se*.

¿En qué momento una persona mayor establece una relación con el personal sanitario? Cuando se convierte en usuaria de los servicios de salud.

El primer contacto de una persona mayor usuaria de los servicios de salud significará la primera relación establecida con el personal sanitario, en general, y con el personal de enfermería, en particular, desde un punto de vista comunitario. Por tanto, la Fase 1 irá encaminada a dilucidar las relaciones de poder que manan desde el primer momento en que la persona mayor pasa a ser usuaria de los servicios de salud comunitarios (**Figura 6**).

Si hay un primer uso o contacto con los servicios de salud comunitarios, habrá una primera respuesta por parte de los servicios de salud comunitarios a tal uso de las personas mayores. Dicho de otro modo: una respuesta institucional, proveniente del personal sanitario en primera instancia, y del personal de enfermería, en segunda.

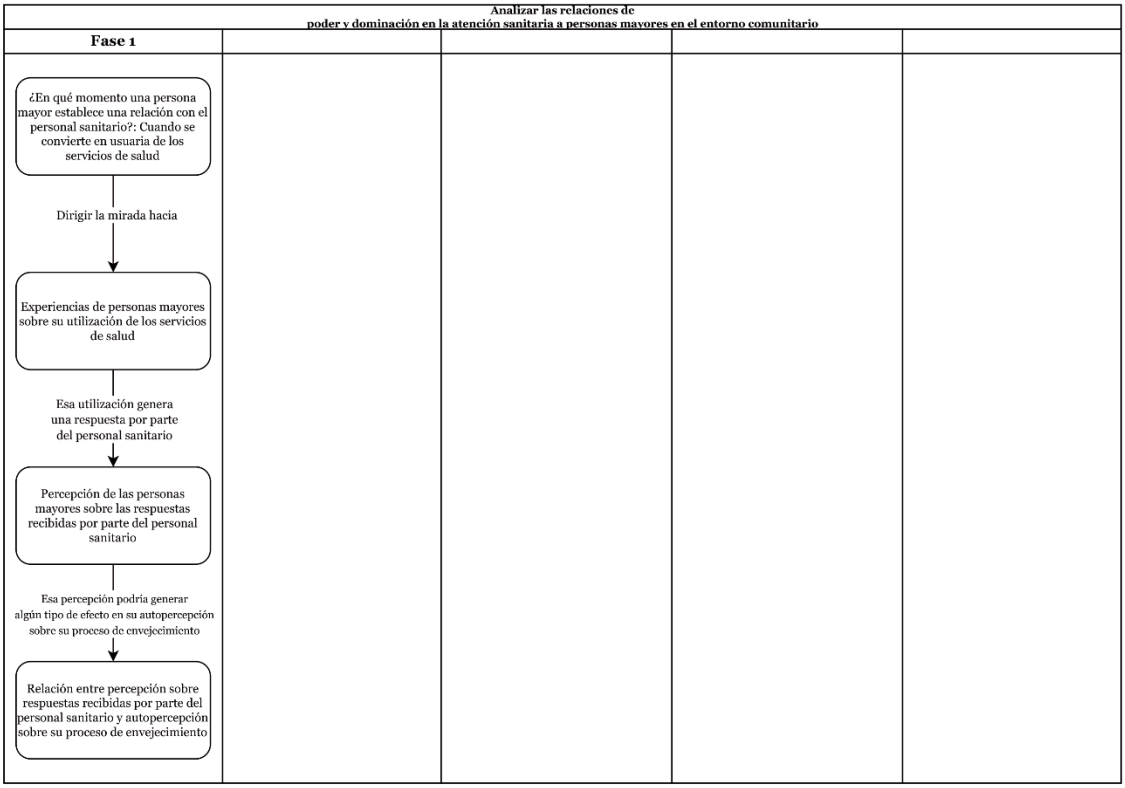

Figura 6. Hoja de ruta de la Tesis Doctoral para la Fase 1. Elaboración propia.

La Fase 1 se realizó desde el prisma metodológico de un AD por medio de la fenomenología con perspectiva crítica, aunando así los principios del ACD. La elección de un acercamiento fenomenológico vino determinada porque permitió obtener una comprensión más profunda de las experiencias de vida de las personas mayores, enfrascándonos en su realidad por medio de sus historias de vida, y logrando así un hondo conocimiento sobre el uso de los servicios de salud y las respuestas recibidas a lo largo de dicho uso por parte del sistema, así como la interacción de la percepción ante estas respuestas con su APE (Byrne, 2001)[8].

[8] Byrne, M. M. (2001). Understanding life experiences through a phenomenological approach to research. *AORN Journal*, *73*(4), 830–830.

Los resultados del ACD a través de la perspectiva fenomenológica arrojaron unas respuestas provenientes del personal sanitario marcadas por una conducta sociocognitiva con tintes claros de edadismo. La flagrante discriminación por edad caló negativamente en el uso que las personas mayores hacían de los servicios sanitarios, desechando la idea de acudir por problemas de salud agudos, al chocar frontalmente con respuestas del personal sanitario que les hacían pensar que estaban "perdiendo el tiempo". La APE de las personas mayores fue negativa en la medida en que también incorporaron una visión edadista de sí mismas, tergiversando su cognición sobre el concepto de ser mayor y repercutiendo en su autopercepción sobre su estado de salud, haciéndoles depender de un sistema sanitario dominante y crudo de ideología claramente desfavorecedora para las y los pacientes mayores participantes del estudio, creando, pues, un efecto bumerán que les hacía volver a la casilla de salida desde el punto de vista de las relaciones de poder.

I. "With your age, what do you expect?": Ageism and healthcare of older adults in Spain.

Title

"With your age, what do you expect?": Ageism and healthcare of older adults in Spain.

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ABSTRACT

Introduction: Ageism could influence the relationship between older patients' meeting needs and healthcare professionals' answers. In addition, the self-perception of aging can be negatively impacted by internalized stereotypes that can affect older patients' use of the health system.

Aims: To highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and to explore the relationship between perceived ageism and SPA.

Methods: We conducted an exploratory qualitative study with a critical perspective. The participants were 14 women over 65 who lived alone in their homes in southern Spain.

Results: Revealed professional responses marked by ageism ignored the expression of preferences of the older patients and excluded them from decision-making processes. These answers influenced older patients' use of health services. Moreover, the negative aspects predominated in a self-perception of aging influenced by the internalization of stereotypes and a relationship weighed down by ageist behaviors on the part of health professionals when consulting acute problems.

Conclusion: Explicit situations of ageism influence an imbalance in power relations between older patients and healthcare professionals, a misuse of health services, and a negative SPA.

Keywords

Health Services for the Aged; Social Discrimination; Ageism; Health Services Misuse; Healthcare Disparities.

INTRODUCTION

Aging: a challenge for healthcare systems

The World Health Organization, in the World report on aging and health, claims that the population is aging faster than in previous years. The percentage of individuals over 60 is expected to double worldwide between 2015 and 2050, from 11% to 22%.[1] Considering these data, the population over 60 would reach 2 billion people worldwide, representing an increase of approximately 900 million compared to 2015.[1–4] These data indicate those older adults as a population segment of increasing dimensions. For this, health services have tried for years to adapt to changes in the progressively aging population's meeting needs, and healthcare professionals have also attempted to adapt to the greater use of the healthcare system made by older people.[1,4–7] However, there are times when healthcare professionals are insensitive to the specific needs of older adults.[8] Healthcare professionals can show, in those cases, negative attitudes toward older patients, influencing the care they provide and giving hostile responses.[9–12] These attitudes are also described, even among health sciences students.[9,13,14]

Ageism as a form of discrimination

According to Butler[15,16], ageism is defined as a type of social and interpersonal discrimination impregnated with stereotypes based on advanced age. This could be identified in a society or a group through specific characteristics such as prejudicial attitudes against the aged, old age, and the aging process, including attitudes held by the older people themselves; discriminatory practices against them, and the existence of institutional practices and policies which reproduce stereotypic beliefs about the older adults, deteriorate their quality of life and limit their dignity. Ageism has become a socially accepted discrimination that creeps into the health care of the older adult

population, generally harming them.[11,17,18] Additionally, the organization of healthcare favors this discrimination. For example, one of the first data we look at to describe a patient is age, interpreting longevity as synonymous with frailty or comorbidity.[19] Although current estimations envision many cases worldwide, it is a huge challenge to know precisely the prevalence of ageism in our society, despite studies that strive to offer ageism measurement tools.[20–22] On the other hand, the systematic review by Chang et al.[23] has shown the effects that ageism causes on health and its prevalence, highlighting mainly the less educated older persons, who were likely to experience adverse health effects of ageism. These consequences cover a wide range of planes in the older person, from a negative structural impact in terms of a denial of access to health services or medical treatment, going through exclusion in the participation of experimental scientific studies, to the extent of prejudicial effects on individual health in biopsychosocial and relational spheres.[23,24]

Aging as a subjective process

Otherwise, although the WHO gives a biological perspective in defining aging, these changes are not linear or uniform and are accompanied by other essential modifications in each subject's roles and social position.[1,25] Considering the above, we can say that aging has the characteristic of universality; that this vital stage could be described as a complex and dynamic process in which all kinds of components intervene, physiological, psychological, and sociological; and consequently, there are objective and subjective components in aging.[26,27] From an objective aspect, it can be understood that aging begins from birth and is associated with advanced-age people. From a subjective element, all the individual's thoughts and feelings regarding aging must be considered because

each person will live and experience this process differently. For this reason, the self-perception of aging is meaningful.[25,28–30]

The importance of self-perception of the aging process (SPA)

SPA refers to how individuals perceive their own aging process, not the aging process in general. This concept is very subjective and varies from person to person. This self-perception will be determined by a series of expectations acquired, on the one hand, throughout the life that precedes old age, on the other hand, throughout the encounters that occur in everyday life during old age.[31] This SPA can be positive or negative, which in turn can cause positive or negative consequences for the health of older people.[32] For instance, older people with more positive self-perceptions of aging at baseline maintained better functional health throughout a longitudinal study and lived longer than those with more negative self-perceptions of aging.[31] At the same time, it has been shown that a SPA based on age stereotypes predicted a worsening in the health of older people.[33] Beyond this, in industrialized countries, it has come to be imposed that aging is equivalent to disease or deficit.[1,34,35] Regarding this social imaginary, the Stereotype Embodiment Theory (SET)[32] illustrates how people can internalize age discrimination, thus affecting SPA by unconsciously acquiring stereotypes through continuous and silent exposure to ageist messages that society sends through the institutions, social media, or education. These messages affect various physiological, psychological, and behavioral outcomes, thus influencing the way older people use health services.

Finally, and as is made clear in the Global Report on Ageism[36], investigating and addressing age discrimination is vital to creating a world in which the dignity and rights of all human beings are respected. In the healthcare world, it has become even more relevant. In line with the WHO's report for the

decade of healthy aging 2021–30[37], this study aims to join efforts posing the following objectives: to highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and to explore the relationship between perceived ageism and SPA.

MATERIAL AND METHODS

Design

We employed a qualitative phenomenological study with a critical perspective. The objectives of our study made us opt for a phenomenological approach since it allowed us to obtain a deeper understanding of the life experiences of older patients within their reality, thus achieving a deep insight into the health meeting needs of older adults and responses received from the system, as well as the SPA.[38] We used the Consolidated Criteria for Reporting Qualitative Studies (COREQ), a checklist of 32 items developed to facilitate detailed and comprehensive research reporting.[39] The checklist is divided into three domains: research team and reflexivity, study design, and analyses and findings (Table 1).

Setting

The study was performed in a community care setting in the Córdoba-Guadalquivir Health Area, specifically in two centers. The province of Cordoba is in the north center of the Autonomous Region of Andalusia (Southern Spain). According to data corresponding to the year 2021 extracted from the Institute of Statistics and Cartography of Andalusia, the province's total population is 322,071 (167,454 females and 154,617 males), whose rate of over 65-years-old population is 19,6%. Within the community care setting, there are thirteen primary care centers and nine consulting rooms in rural areas. One of the two health centers was responsible for primary healthcare services of the sixth poorest suburban district in the whole country, according to the Urban Indicators in its 2022 edition provided by the Spanish National Institute of Statistics.[40]

Study participants

The sampling performed was purposive. The following selection criteria were established:

A. People over 65 years of age.

B. These people must live alone in their homes.

C. The people had made at least one health consultation in the last thirty days.

Furthermore, the exclusion criteria were:

A. Suffering from cognitive impairment.

We arranged a meeting with nurse case managers from the two health centers. We informed them about the selection criteria of our study. After consulting the active patient databases of each center and sharing their specific knowledge about possible key informants, the nurse care managers suggested to the team the potential participants, showing the characteristics of each and contextualizing the criteria of inclusion to be met. All the participants suggested by the nurse care managers were considered for inclusion in the study. After that, the reference nurses of each patient were informed by the nurse care managers about the consideration and proceeded to have first contact with the potential participants to tell them about the existence of the research project and thus verify their possible interest in participating. All the older people wanted to receive more information about the research project from the researchers. Each reference nurse arranged a face-to-face meeting between them, the potential participant, and one interviewer from the research team at an older adult´s home. The place for the meeting and the time slot was decided and agreed upon with the

potential participants. After that meeting, in which all the information related to the project was explained to potential participants, they were asked if they would be willing to participate. All the older adults agreed to participate, signing the informed consent sheet properly and arranging a second visit to conduct the interviews. The saturation of the discourse was determinant for reaching the final sample size.[41]

Interview script

The general interview script topics were the SPA of the participants; their meeting needs for healthcare, the healthcare professionals' responses received, and the possible moments of suffering ageism (Supplemental file 1).

Data collection

A total of 14 in-person semi-structured interviews were conducted. A first script was prepared before completing the relevant interviews. A suitable environment was always sought to allow these interviews to be shown in the most comfortable way possible for the participants and, in turn, obtain sincere and profound answers. According to and following the participants' wishes, that environment was their own home. Initially, the interview was introduced through open questions so the participants could answer freely and convey their first impressions. Subsequently, the interview was structured and guided around more direct questions. All interviews were audio-recorded and accompanied by a field notebook where the interviewer added information. After that, the recordings were transcribed and imported into the QSR NVivo 12 qualitative analysis software tool for subsequent analysis.[42] The duration of each interview lasted between 60–80 minutes. The caregivers of patients 8, 10, and 11 were also present during the interview.

We understood translation in qualitative research as an essential process to accurately convey participants' meanings between languages; hence we intended to ensure the trustworthiness of this qualitative research.[43] The interviews were conducted in Spanish, which was the original and native language of both the participants and the research team. Therefore, our translation process began in the dissemination phase of our work in English.[44] During this process, we translated the research, so we adopted the figure of researcher-translator, advised by a native English speaker. We identified some cultural difficulties when translating metaphors and personal expressions to convey the exact meaning of the older patients´ discourse in our experience, something that we addressed to the native English speaker and worked alongside her to reach a consensus in translation.

Data analysis

Content analysis has been performed to interpret and synthesize the information collected through the hermeneutical considerations proposed by Ricoeur.[45] The first step after transcribing the interviews was an in-detail reading to create an explanatory framework based on the main ideas gained using the starting categories. In the first phase, each idea or statement that was complete enough to be informative was designated as a node. Based on the initial category, the found nodes were classified into a category according to the presented cognitive dimension. Second, categories and subcategories were defined by the recombination of nodes within each pattern; in this way, the nuances of each pattern were provided by the taxonomy branch, which in turn was supplied by the subcategories. Finally, a deep understanding of patients' experiences was sought in the third phase, which would close the so-called interpretation arc. In

addition to the verbal discourse, the participants' non-verbal language and various manifestations when expressing their answers were considered to perform this analysis.

Rigor and Quality Guarantee

For the rigor and methodological quality of this study, see Supplemental file 2, where we provided a detailed and in-depth description of the following sections proposed by Calderón.[46]

Ethical and legal aspects of the study

The participants were informed before attending the interviews. They were previously told that the data collected would be used only for research purposes and that all identifying information would be anonymized. The participants were also informed of the research objectives, how their personal information would remain guaranteed, how the data would be disclosed, and that they could stop the interview whenever desired. At all times, the anonymity of the person was guaranteed. In addition, the study has the permission of the Ethics Committee for the province of Córdoba.

RESULTS

Description of the participants

All the older people participating in this study were white Spanish women, with a mean age of 85 (Table 2). The participants' health information was obtained by consulting their medical and nursing records through the nurse care managers. The socioeconomic status was obtained by self-reported through a direct question to each participant outside the interview script provided.

Conceptual map for the synthesis of the results

In an illustrative manner, the results seen in Figure 1 exemplify how the use of the health system that older women who live alone made could transform a misuse due to a poor attitude and praxis on the part of the professionals. Healthcare professionals created an imbalance in power relations that made these older patients an oppressed group in the eyes of the system.[47] Older patients saw how their dignity and right to receive quality health care are resented. On the other hand, healthcare personnel turned into a sometimes-oppressive group that took advantage of professional superiority, leaving older patients unsatisfied with the care they genuinely deserved.

Narrative development of the results

The results of this study describe the meeting needs that older women have for healthcare services and discover ageist responses from healthcare professionals. These responses influence the misuse that older patients make of these services. Through the older participants' statements, we have identified that they mostly share a negative SPA, influenced by internalized stereotypes about aging and ageism by healthcare professionals.

Use of healthcare services by older patients: an imbalance

One essential aspect of this work is the use of healthcare services. Concerning this, most participants' responses were consistent and homogeneous. Firstly, we should differentiate between a consultation requested as a follow-up —a routine consultation, a revision related to a chronic process— and a consultation for a specific reason. The older adults understood the latter as an occasional problem at a particular time that we could identify as an "acute process". This distinction existed because different answers were obtained regarding both situations during the interviews. So, concerning the frequency with which they used health services when referring to consultations related to periodic revisions, checkups, or control of some chronic process, most participants answered that they attended these visits. In contrast, a low level of consultation was generally observed for acute problems:

"I go scarcely." (Participant 1).

"I go from time to time." (Participant 5).

"I only go to my checkups." (Participant 14).

This was justified by the perception of need that each of the participants had, or lack of joint planning between healthcare professionals and older women, like participant 4 conveyed when the nurses made appointments for her without any previous consideration:

"I go when I need to." (Participant 14).

"When I have an appointment or something, if they tell me... maybe they'll call me very early. It's harder for me to get up. I mean oh please, can't I have that later?" (Participant 4).

Most participants reported not consulting a healthcare professional when a health problem occurs. In the case of doing so, they perceived that problem as challenging when it had not been remitted after self-medicating. In this sense, we found that self-management of their health was frequent. Older patients opted to self-medicate when they had any ailment or physical distress; therefore, on many occasions, they did not see the need to seek professional help:

"I just go when it´s something serious." (Participant 2).

"[I go] when there´s something that is not going away, but I´m good with some painkillers for so long." (Participant 3).

"I think I don't need anyone right now, you know?" (Participant 4).

In addition, there were specific cases in which the previously stated reason must be added to the existing physical limitations that discouraged them from consulting: "No, I just can't walk well... I don't go out." (Participant 13).

Responses from healthcare professionals: ageism at the root of care.

The participant's perception of the responses they obtained when making a consultation came with experiences and impressions with practically no positive aspects. One aspect that emerged frequently was a lack of time. There were experiences in which the health professionals told them that it was not possible to attend them due to insufficient time:

> "The last two times I went to the nurse, I told her to look at my [blood] sugar, and she said that she couldn't and that she didn't have time. That has happened to me several times." (Participant 2).
>
> "Once, when I went, a couple entered the doctor's office and stayed there for more than half an hour. Then the doctor came out: look, I cannot spend more than 5 minutes with you; I close the consulting room at eight. I can´t dedicate myself to this, be aware of that." (Participant 3).

The participants even reported situations in which a lack of time must be added to an imposing nature on the part of the staff who attend them. Examples arose when the health professional did not listen, thus, giving immediate, reactive, and mechanical responses:

> "He was going to give me some pills, and I said: Look, be careful; I'm allergic to medicines. Look at the computer. The doctor said: You have to take this because I don't have time to look at the computer." (Participant 7).
>
> "You know? And I told the doctor not to send [the pill]it to me. That he couldn´t send it to me because he was doing many blood tests on

me, how it was... But nothing. Even if I begged, nothing." (Participant 10).

However, it was a matter of haste and inattention to older women's routines. Far beyond not listening, there was no consideration of the clinical condition, and there was no predisposition to listen or to pay attention to the older patients' preferences. In other words, the patient was not considered at all. As an example of this situation, participant 2 told us that she repeatedly visited the social worker and the nurse case manager to request a home care visit service. She explained how the appointment times did not suit her situation:

"My problem is that I live alone. And I get no solution for that. And who would think of scheduling an older woman for an appointment at 8 a.m.? I live close by, but I can't go alone because it's still dark and raining. How outrageous!" (Participant 2).

Regarding home visits, it was no different. The participants reported that they were excluded from the planning of agendas, and there were plenty of occasions when professionals used to arrive home without previously notifying the older patients of the incipient visit:

"The nurse comes directly because she knows that I'm always here... Does not call." (Participant 9).

"She comes, sometimes she let me know, some others not. She has her day. Depends on how things go." (Participant 6).

However, beyond a lack of time and not considering the patient when planning agendas, older patients generally perceived a lack of interest from the healthcare professionals. For instance, when asked during the interview if older adults thought that professionals were interested in their health condition in a consultation or if older adults received any interest expression from healthcare personnel, we got answers such as the following:

> "They don't usually... this doctor that we have now, he doesn't usually ask much; he sends you off right away." (Participant 5).
>
> "What [the nurse]she says is that she has to attend to many people." (Participant 9).

Moreover, they reported a lack of concern among healthcare professionals about older patients' problems. There were some experiences in which the professional ignored a noticeable health problem:

> "Well, once I went to the doctor because I had awful pain in my legs. He was in front of the computer and wasn't telling me anything. That is not listening to you, that is not paying attention to you, that is not having any idea of being a doctor, that is not having any idea of anything else." (Participant 5).
>
> "And why didn't he operate me? And every year... And here I am, when the pain wants it hurts me..." (Participant 13).

Perhaps, the most graphic example of this situation was reported by participant 8 when explaining that posing a health problem has been

accompanied sometimes by the following statement from healthcare professionals:

> "Sometimes they tell me: with your age, what do you expect?" (Participant 8).

One of the participants specifically mentioned having consulted her general practitioner (GP) due to severe jaw pain not remitting for days; she requested to be referred to a specialist because the pain prevented her from eating. She mentioned that her GP told her it was because of osteoarthritis without even examining her. On the day of the interview, a month later, she was still in pain and had still not been treated:

> "He is stringing me along, the ear washing... Now he has referred me to the dentist but not the one I wanted him to refer me to; no, I requested it. I was the one who told him... That I don't usually do that, you know? Nevertheless, I saw that my ear hurt and that I couldn't open my mouth and, ouch! It still hurts... (at that moment, she opened and closed her mouth, and it heard the crack) ... That is osteoarthritis (she imitates the doctor with a tone of indifference). Well, osteoarthritis, and if you refer me to the specialist, won't I be calmer? He discarded that, and we already say: well, we already know that [pain]it doesn't come from the inside of the ear, but I have been left with the desire because he has not referred me" (Participant 5).

Sometimes, the older patients' demands were ignored and perceived as "calls for attention" to obtain the interest of healthcare staff:

> "Because I call my family doctor... and he says: well, what are you calling me for? I told him that I had called because this had happened to me. Furthermore, he says: what you want is for me to see you? And I say, well, you look at me and tell me what happens to me. The doctor replies: It's silly; if I can't prescribe you medicines because you are allergic, I can't prescribe you anything. Then, goodbye. Then why am I going to call him?" (Participant 7).

In addition, they reported situations in which care lacked respect, and even harm was sought:

> "Moreover, I have even suffered mistreatment. They are stubborn about self-injecting me, and I have been stubborn about that. I'm not going to give the injection by myself; they have to give me the injection, and they are getting paid for that. One took one day and gave me such a pinch that she left me bruised for two weeks." (Participant 3).

> "And I say, what is that? And he says, well, you could die. I say, oh my God! Don't tell me those things, man. Anyway, he was going to give me a pill, and I say, oh, please, look at you, you should be careful because I am allergic to some pills. Look at the computer. He says: I don't stop at that, you must take this, and that´s all." (Participant 7).

Participant 7 even reported similar experiences in the case of hospitalizations. She told about the bad experience she had when she was admitted to the hospital, and the staff bathed her with cold water every day:

> “When I was admitted, a b**** wanted to bathe me every day, and I asked her why? If I don't even have dust. I wouldn’t say I liked how they treated me. And I let them, but they did not add cream or deodorant or anything, and I need cream because I am very particular about that. However, it turns out that one of them had a fixation with me because I felt very cool with my dyed hair. Also, she was taking a bucket of cold water and pouring it over me. She befuddled me. I asked the nurse what I had done to make her treat me like that when I have always treated everyone with respect. Hasn't anyone told you that you are a b****? You could have thrown the bucket on yourself. And she laughed.” (Participant 7).

SPA in older adults: a negative conception

Despite everything described in the previous point regarding the ageism existing in healthcare professionals, older patients not only did not consider that healthcare professionals treated them differently because they were older but also felt that they were treated even as if they were younger, something that they considered to be beneficial:

> “No, because they see me young and are surprised that I am 81 years old. They see me well. Because I'm very active... They treat me better; they see me young.” (Participant 2).
>
> "No, no, the age... They have treated me as if I were young." (Participant 11).
>
> "She receives me as if I were 20 years old." (Participant 12).

In addition, not only did the older participants' discourses link their SPA with ageism but also to their self-perception of health. In this sense, answers were obtained regarding the physical, social, and emotional health spheres. In all of them, the participants showed mainly negative aspects. Concerning physical condition, the older adults reported feeling pain, tired, and, on some occasions, physical distress:

> “It is tough for me to go to the health center. It's hard for me now because I get exhausted, and I arrive there without breath...” (Participant 8).
>
> “Osteoarthritis is not operated. Well, what I have is pain. What a pain I got...” (Participant 12).

Concerning the social sphere, the older patients highlighted the need to receive help when performing the basic activities of daily living in most interviews:

> “I would need a young lady to come and help me around the house and help me go shopping.” (Participant 2).
>
> "I went to the social worker because I would need a woman once a month or every two weeks to clean the lamps, the furniture on top." (Participant 3).
>
> "What I need is a woman to come in the afternoon, in case she can take me out because I can´t go by myself." (Participant 1).

Regarding the emotional aspect, they referred to an apathetic state, even going into issues related to a lack of will to live. Participants underlined the monotony of life and how little hope they had to move on:

> “I am sick of living, sick of living, because this is always the same, always the same.” (Participant 7).
>
> “Any day I will be found dead.” (Participant 1).

Regarding living alone, one of the inclusion criteria when selecting participants for the study became the cornerstone of this subtheme. Older women did not just live alone. In addition, they sometimes felt lonely as they had lost their spouses, and even several of them had lost their offspring or could not count on close people.

Adopting a joint vision of the results obtained, the relationship between the older patient-healthcare professional was loaded with evaded, undervalued,

and even ignored meeting needs. On the other hand, the existence of frustrating responses from healthcare professionals meant that older patients did not see their needs met and that they understood the use of the health services as a waste of time and something completely useless. Despite all this, the participants claimed to be free when expressing their opinions or preferences during consultations:

> "I have no problem about saying something. Sometimes, I tell my family doctor that my evenings seem very long." (Participant 9).
>
> "I am inquisitive, so once I asked her what the little bottle that I have in the fridge was for, the one that she puts on me when she comes, and she explains it to me, yes, yes." (Participant 6).

DISCUSSION

Concerning the above-described health situations, the participants in our study affirmed that they did not usually consult a healthcare professional when having an acute health problem. This statement is inconsistent with most scientific literature, classifying older adults as hyper-users of the healthcare system.[48–50] However, the literature clarifies that this hyper-attendance shows differences depending on socioeconomic status because low status is related to increased primary care visits. In contrast, those older patients with a high socioeconomic status attend more specialized care consultations.[51–54] Furthermore, to explain this over-attendance, various studies reported that meeting needs are frequently associated with chronic diseases, such as diabetes mellitus, high blood pressure, and cardiovascular diseases.[48,55] This is consistent with the present study results, where the checkups and periodic revisions in healthcare centers have been the primary references that the participants gave. In any case, it is relevant that the participants in our study stop visiting health professionals when a health problem has occurred. Perhaps, this fact is better understood if we consider previous studies reporting how most older adults have a terrible opinion of the care they receive; they even show signs of mistrust.[56–58] Furthermore, this satisfaction was even lower when the older patient's functional limitation was more significant or when a persistent feeling of loneliness prevented the patient from visiting the general practitioner.[59–61] For this reason, patients may feel frustrated, which will probably lead to the non-use of health services in case of acute problems.

The results of the present study show the ageist responses that health professionals gave to the meeting needs of older patients when they attended the

consultation. These older patients, therefore, were a group affected by their condition of advanced age, compared to another group that exercised a role of power through an ageist attitude. This is consistent with Van Dijk's theory of power relations,[47] which states the power imbalance between social groups through reproducing an oppressive discourse against an oppressed group. This fact is reinforced by the principles of Social Identity Theory (SIT),[62,63] which explains the complex network of attributes that shape intragroup relationships and behaviors, in this case, of older patients and healthcare professionals. From this socio-cognitive prism, the SIT points out the existence of mechanisms of distorted differentiation between groups that cause this power imbalance. The social categorization present in the results of our study brought a conflict between groups that pivoted around age as a category that causes social stigma.[64] According to the SIT, the ageism of healthcare professionals characterized their social identity as a privileged group, which conceived and referred negatively to the outgroup of older patients.

On the other hand, the results of our study show that older women had a negative SPA marked by a self-ageist conception in most cases. This, in turn, agrees with the SET[32], which explains the gradual assimilation of age-stereotyped concepts unconsciously through encounters full of mostly pejorative social signals, continually letting them know they were older. These signals come from the same institutions, which also agrees with what is shown in this study. In line with the SET and consistent with the results of this study, there are longitudinal and experimental studies that demonstrate the negative influence that ageism has on SPA in older people, to the extent of finding that ageist stereotypes harm SPA and also act as a predictor of health.[33,65,66]

Besides, some older patients reported not only that they did not feel treated differently due to being older but also that they felt treated as if they were young, which they considered beneficial. This apparent contradiction has its explanation in the Self-Categorization Theory (SCT),[67] which delves into the depth of the comparative construct of identities at the same level of abstraction and the consequences self-categorization has for the individual. Older women who said they felt active or younger were evaluated more positively than their peers who did not share this feeling, which allowed them to differentiate themselves from members of their same social group. This agrees with the SIT to the extent that being older was considered a negative social identity, so older women who said they felt young identified it as something positive. This led them to try to cross the group barriers they considered to be permeable to be seen as young people and, therefore, belong to a higher-status group. This phenomenon within the SIT corresponds to an attempt at social mobility. Furthermore, it would also be equivalent to what Luken[64] defines as reclassification because these older women identified being older as a discrediting attribute. This identification caused a desire to be reclassified in another social group of a better position. In conclusion, this was just another sign that, in the form of an acquired self-stereotyped attitude in the case of older people and in the form of an oppressive attitude in the case of healthcare professionals, ageism is a socio-cognitive web that permeates the social relations between both groups[68].

CONCLUSIONS

The use of healthcare services was primarily high regarding attendance for chronic issues in older patients and not for acute issues despite recognizing negative health states. However, when they decided to consult for an acute health problem, they suffered from ageism by healthcare professionals as a response because these problems were underestimated and blamed on advanced age. The care received from the healthcare professionals in those situations presented clear areas for improvement since the health problems of older patients were ignored, ineffective results of the treatments were tolerated, and even abuse situations were reported. Therefore, older patients considered consultations a waste of time. On the other hand, older patients showed a predominantly negative SPA, influenced by internalized ageist stereotypes and age discrimination from healthcare professionals. In addition, the older women related their SPA with their self-perception of health, which was also negative. In some cases, older women said they felt active or young and highlighted this as beneficial when dealing with healthcare professionals. However, this was nothing more than a reflection of an ageist conception within their SPA.

Study limitations and further considerations

Regarding the characteristics of the participants, all in this study were older women, so that this fact may have influenced the results somehow. Not having older men among the available sample has possibly determined the nature of the perceptions we studied and has prevented us from applying a gender perspective segregated by sex or gender. For this reason, it would be advisable to conduct future research that ensures a sample as homogeneous as possible between men and women to discover possible peculiarities and differences between sex or gender. According to the older participants' experiences, the results of this study address a relationship between interpersonal ageism and SPA of older adults, thus considering SPA a multifaceted phenomenon. This added that many elements spin the context and interact in these situations; diving deeper into this topic becomes necessary. We decided to focus our study on older people who lived alone because it was a characteristic associated with vulnerability in advanced age. Some recent studies linked a negative SPA with loneliness, isolation, and depressive symptoms.[69,70] This evidence has influenced our results to the extent that they also point towards a negative SPA. Considering other older patients in more varied social circumstances could have provided some possible variation or deepened the differences between SPA.

Relevance to clinical practice

Giving older people a voice in the context of their care is vital to understanding their state of health and the elements that shape their use of health services. Although fourteen interviews with older women cannot be considered representative of the experiences of all older patients, they could be transformed and applied to resemblant situations. Considering this, this study makes visible the older adults as a group prone to being vulnerable that sometimes suffers from the oppression of a health system in occasions paternalistic, plagued with ageist responses that reproduce through the discourse of the participants. In this age discrimination, there is an imbalance of power in relations between social groups.[47] This is crucial to provide a critical vision within the organization of the health system and our performance as health professionals. The results of this study shed light on a reality that leaves room for improvement in the professional approach to one of the axes of health care, such as the older patient, for which we suggest the reinforcement of clinical interventions that are based on respect and moral consideration in processes such as shared decision-making, the opportunity for older people to express their preferences in care and to encourage their active participation in these processes. Furthermore, we can affirm that the older participants in this study provided relevant information from a holistic healthcare perspective, allowing the reader a profound understanding of their inner reality and use of healthcare services.

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Tables, figures and supplementary material

Domain 1: Research team and reflexivity	Description
Personal Characteristics	
1. Interviewer/facilitator Which author/s conducted the interview or focus group?	PMA and MMM conducted all the interviews.
2. Credentials What were the researcher's credentials?	PMA was a Ph.D. student and MSc in Health sciences research. MMM was an RN. MRR, PVP, VCH, and SLQ were Ph.D.
3. Occupation What was their occupation at the time of the study?	PMA was working as a Research Fellow at the University of Córdoba (UCO). MMM worked as a nurse at the Hospital Universitario Reina Sofía (HURS), Córdoba. MRR and SLQ were working as full professors at UCO. PVP and VCH were working as assistant professors at UCO.
4. Gender Was the researcher male or female	PMA, MRR, PVP, and SLQ are male. MMM and VCH are female.
5. Experience and training	PMA had experience in qualitative research from previous works. He received a Master's degree in Health sciences research from the University of Jaén (UJA),

What experience or training did the researcher have?	Spain. In addition, he underwent formal Ph.D. education in qualitative research and gave teaching lectures during his fellowship.
Relationship with participants	
6. Relationship established Was a relationship established prior to study commencement?	There was no previous relationship with any interviewee since the interviewers of the research team knew them at the time of data collection. PMA had a prior relationship with the rest of the group. MRR and SLQ researcher were their doctoral thesis supervisors; MMM, PVP, and VCH were colleagues from the department.
7. Participant knowledge of the interviewer What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	PMA and MMM informed the participants that the research project belonged to a thesis project of PMA. The two researchers told the older patients that their purpose was to find out their use of the health services and what answers they received from healthcare professionals, in addition to knowing how they perceived themselves based on their moment in life. When the participants asked questions about the project, they were answered by both researchers.
8. Interviewer characteristics What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	The principal interest of PMA in the topic was based on his desire to focus its thesis project and future research on situations of social injustice, imbalance of power, and possible discrimination in care contexts on the health and disease processes of vulnerable older people.

Domain 2: study design	
Theoretical framework	
9. Methodological orientation and Theory What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	The research paradigm for this study was phenomenology with a critical perspective. Using phenomenology, researchers could dive into the reality of other individuals. Using a critical perspective, the researchers had a reflective approach to possible social injustice and discrimination situations to locate care failures and highlight areas for improvement in the care from health services. In this study, we aimed to highlight the experience of older adults with healthcare systems, how they perceive ageism from their healthcare providers, and explore the relationship between perceived ageism and SPA. Following Ricoeur's hermeneutical considerations, content analysis was used to understand older people's interpretations of their life experiences.
Participant selection	
10. Sampling How were participants selected?	The article explained the sampling method, and all approached older patients agreed to participate.

e.g. purposive, convenience, consecutive, snowball	
11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email	The method of approach is explained in the article.
12. Sample size How many participants were in the study	In total, 14 interviews were conducted. The interviewees were older women who lived alone in their homes.
13. Non-participation How many people refused to participate or dropped out? Reasons?	None of the participants who were asked to participate refused to be part of the study or withdrew from it at any time.
Setting	
14. Setting of data collection Where was the data collected? e.g. home, clinic, workplace	The interviews took place at the participant's preferred location. This location was their home.

15. Presence of non-participants Was anyone else present besides the participants and researchers?	Caregivers were also present at the interviews with participants 8, 10, and 11. During the other interviews, only the participant and the researcher were present.
16. Description of sample What are the important characteristics of the sample? e.g. demographic data, date	All participants´ characteristics are described in Table 2.
Data collection	
17. Interview guide Were questions, prompts, guides provided by the authors? Was it pilot tested?	The authors provided the interview script as supplementary material to this article. Considering the semi-structured and dynamic nature of the interview, the interview script topics were used as a guide for the interviews. Still, they were open to more than the content of the interviews. The list of topics was adjusted to each participant's uniqueness throughout the research interview phase.
18. Repeat interviews Were repeat interviews carried out? If yes, how many	Repeated interviews with the participants were not conducted. As for the patients, this was due to their multimorbidity and because many reported their state of fatigue concerning the realization of interviews.

19. Audio/visual recording Did the research use audio or visual recording to collect the data?	All interviews were audio recorded with the participant's verbal and written consent. The recordings were stored on PMA and MMM computers because they were responsible for data analysis. Only they had access to this data.
20. Field notes Were field notes made during and/or after the interview or focus group?	The audio recording was accompanied by a field notebook which included observations and impressions that were not recorded, such as the non-verbal communication of the participant. Field notes were used in the analysis of the results afterward.
21. Duration What was the duration of the interviews or focus group?	The duration of each interview was between 1 and 1h 20 min.
22. Data saturation Was data saturation discussed?	Data saturation was discussed with the research team.
23. Transcripts returned	Due to various reasons (such as the limitations in the reading of most of the patients due to medical or literacy issues; a state of exhaustion after the completion of the

Were transcripts returned to participants for comment and/or correction?	interviews), the transcripts were not returned to the participants for comments or feedback.
Domain 3: analysis and findings	
Data analysis	
24. Number of data coders How many data coders coded the data?	PMA and MMM performed the data coding and the whole process of analysis simultaneously. Further information is reflected in the article.
25. Description of the coding tree Did authors provide a description of the coding tree?	No coding tree was used. The themes were derived from the data, following Ricoeur´s considerations for hermeneutical content analysis in the data analysis phase. The authors provided narrative and visual development of this process in the article.
26. Derivation of themes Were themes identified in advance or derived from the data	The themes were derived from the data and were discussed and agreed on by all the authors.

27. Software What software, if applicable, was used to manage the data?	QSR NVIVO and SimpleMind Pro were the software tools for managing the data.
28. Participant checking Did participants provide feedback on the findings?	Due to several reasons, as explained at number 23, there was no feedback from the participants on our findings. During the interviews, the interviewers repeated and summarized the answer of the older participant to ask for clarifications and confirmation of the researcher's interpretation of the answers. At the end of the interview, the researcher gave a summary of the content to ensure the researcher understood the main content correctly. At the end of the interview, the researchers also asked the older participants a final question about possible comments they wished to make regarding what had been said and potential topics that were not raised through the conversation but that they wanted to make explicit.
Reporting	
29. Quotations presented A Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	The results section is illustrated with quotes from the participants. Each quote is identified with a participant number. To safeguard the anonymity of older participants, the quote numbers do not correspond to the numbers in Table 2.

30. Data and findings consistent Was there consistency between the data presented and the findings?	According to our assumption, the data presented in the study and the results that emerge from them are consistent.
31. Clarity of major themes Were major themes clearly presented in the findings?	The main themes are present in the results section of our article. Each theme is assigned a different heading.
32. Clarity of minor themes Is there a description of diverse cases or discussion of minor themes?	The minor subthemes are described, along with the main themes and specific quotes for each one.

Table 1. Report using the COREQ checklist for reporting qualitative research.

1) How do you feel? Tell me about your **health condition.** *("ailments" or significant problems?*)
2) **How do you see yourself** regarding your age? (*self-perception*)

3) When **you feel unwell**, do you consult a professional? [yes/no] (*healthcare utilization*)
    4) [**"In case of no**"], why not do it?
    Reasons (*of "why not" goes: it does not matter? Why?*)
    5) ["**In case of yes**"], how many times do you go? (*frequency*). Why? (*Reasons*)

6) If she goes by her own decision or someone makes that decision (*interferences*).

7) **Do you have medical treatment? How do you manage to follow it? Do you find it difficult?**
    8) ["**In case of yes**"], why? *Reasons*.
    9) ["**In case of no**"], Point out if it is problematic because it does not suit her (their characteristics) or her lifestyle/ daily life.
10) Do you come to **periodic reviews**? Is it difficult for you to come?
    11) ["**In case of yes**"], why?
    Reasons (*e.g., thinking it is unnecessary, problems with health personnel, lack of time, fear of a diagnosis…*)

In general:

12) Do you feel that the healthcare professionals **listen to you**? (Point out if she *perceives* something wrong)

13) [In case she had a **preference**, find out if she was able to tell the health personnel: **give your opinion/ choose**]
14) Do you feel that **they care about your problem**? (*Identification of the problem*)
15) **Do they ask you** if you follow the treatment, if you can do it, and how it is going…? (*interest*)
16) [And when "things are not going well"], **do you feel they worry** about that? (*concern*)
17) [If ever "things did not go well"], **were you able to tell the health personnel**? **Did they listen to you / did they take you into account**?

In the end:

18) Do you think they treat you **differently** because of your age?
19) **What do you think healthcare professionals think of older people**?

Supplemental file 1. Interview script.

Rigor & Quality criterion	Description
A. Methodological and theoretical-epistemological adequacy.	The qualitative model is the one that best meets the purpose of this research, as it allows flexible, open, and changing study designs that facilitate the understanding of the subjectivity of the participants. This methodology aims to describe and understand older patients´ experiences, which are affected by the cultural, political, social, and economic context. The interviewer-interviewee interaction here is considered essential for the study's correct approach since it will be the tool that provides the information, which is why it must always be based on respect and the absence of moral judgment in the face of any perspective raised.
B. Relevance.	Understanding the thoughts of older adults about the care received, as well as their perception of how the health professionals manage the care demands, could generate knowledge with clinical and research implications since it would help to explore their real experiences under caring needs situations and thus strengthen the promotion of health and well-being of this group. In addition, the methodology used would favor the results' transferability to other similar contexts.
C. Validity.	This was ensured through triangulation by researchers, sharing and discussing decisions and findings. Moreover, two researchers conducted the analysis process simultaneously, posing the results reciprocally and agreeing on the final outcomes. The rest of the team supervised and approved the overall process.
D. Reflexivity.	The research team was concerned with discovering how much health professionals listen to older patients' demands. For this, and as a reflection of themselves in an older person's mind, the research team wanted to highlight the importance of the difference between being older

	and feeling older. On the other hand, the research team thought about the vulnerability of older people who live alone, so living alone was adopted as one inclusion criterion for this study. Finally, they inclined that the health professionals would probably not be meeting the needs of older patients in their entirety concerning the objectives of this study.

Supplemental file 2. Rigor and quality criteria.

Participant No.	Age	Health condition	Social support (type)	Economic difficulties (with help)
1	68	Hypertension, osteoarthritis, overweight, type II Diabetes Mellitus.	No	Yes (no)
2	81	COPD, intolerance to physical activity, urinary incontinence.	No	Yes (no)
3	81	Asthma, hearing loss, stroke.	No	Yes (no)
4	95	Bladder cancer (operated), intolerance to physical activity, cataracts, urinary incontinence.	Yes (family)	No (no)
5	86	Heart failure, osteoarthritis, type II Diabetes Mellitus.	No	Yes (no)
6	88	Constipation, hip replacement, hypertension, Ménière's disease, osteoarthritis.	No	No (no)
7	78	COPD, intolerance to physical activity, smoking.	Yes (friends)	No (no)
8	84	Intolerance to physical activity, obesity, type II Diabetes Mellitus.	Yes (formal caregiver)	Yes (yes)
9	97	Duodenitis, gastritis, hypertension, mild renal failure, mitral regurgitation, urinary incontinence.	Yes (family)	No (no)

10	86	Atrial fibrillation, epicondylitis, hearing loss, hypercholesterolemia, hypertension, intolerance to physical activity.	Yes (informal caregiver)	No (no)
11	90	Colonic diverticulitis, coxarthrosis, discarthrosis, dizziness, glaucoma, gonarthrosis, hypertension, ischemic heart disease, osteoporosis, type II Diabetes Mellitus, urinary incontinence.	Yes (formal caregiver)	No (no)
12	84	Atrial fibrillation, breast cancer, colon adenocarcinoma, knee osteoarthritis, obesity, urinary incontinence.	Yes (family)	No (no)
13	83	Osteoporosis, urinary incontinence.	Yes (family)	Yes (no)
14	90	Dizziness, gonarthrosis, hearing loss, heart failure, hypercholesterolemia, hypertension, intolerance to physical activity, spondylarthrosis, tinnitus.	No	Yes (no)

Table 2. Characteristics of the participating older patients

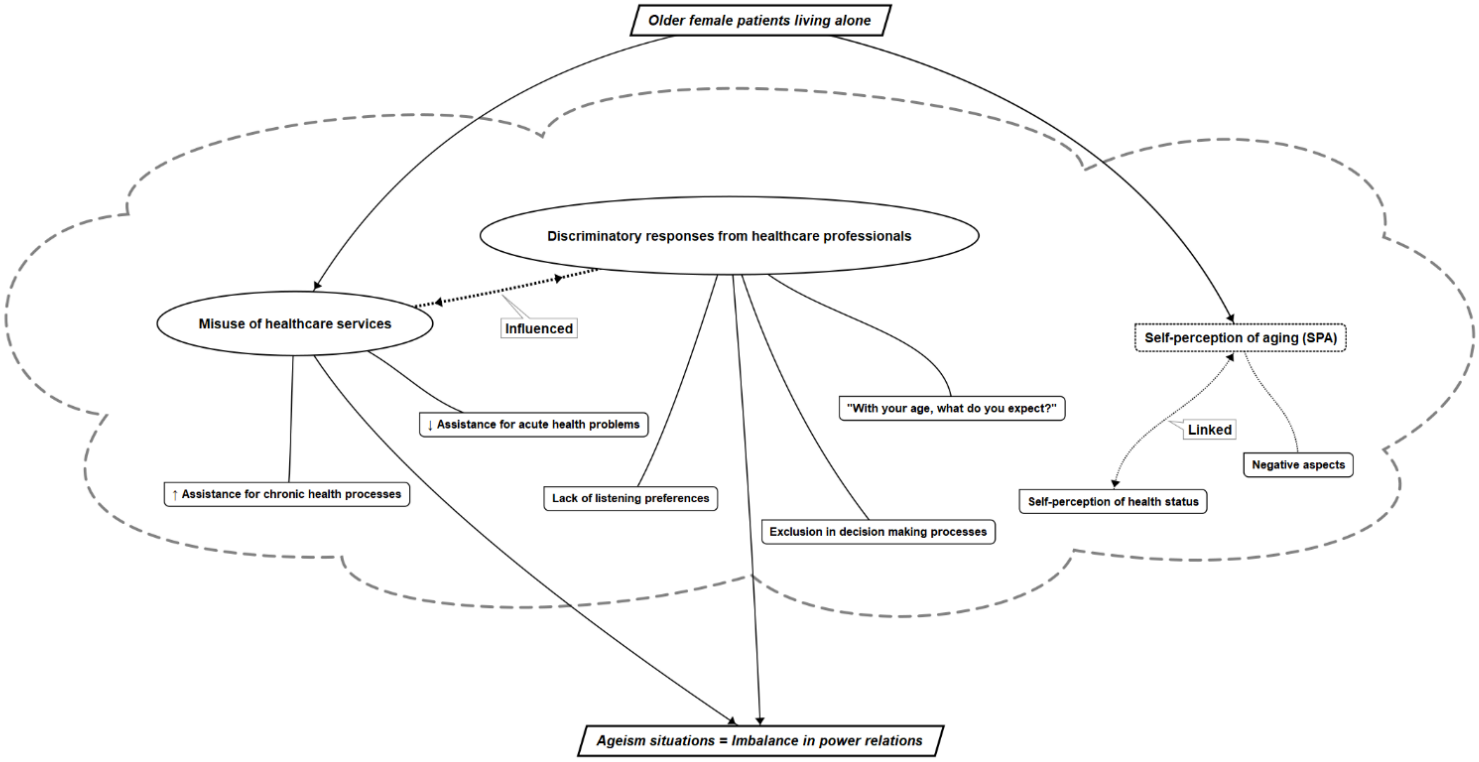

Figure 1. Ageism, power relations and their elements between older patients and healthcare professionals.

SÍNTESIS EN ESPAÑOL DE LA PRODUCCIÓN II

Los resultados y conclusiones derivadas de la Producción I fueron demoledores.

Sin embargo, mi Tesis Doctoral debía seguir caminando en pos de encontrar la respuesta a todos y cada uno de los Objetivos planteados.

Debía acotar el cerco, ceñir la búsqueda de la respuesta a situaciones clave donde las personas mayores tuvieran la oportunidad de adquirir un rol de poder, tuvieran la oportunidad de empoderarse y equilibrar la balanza hacia una ensenada donde fondee la embarcación de la justicia e igualdad social: donde el personal sanitario y las personas mayores sean uno, un equipo. En dichas situaciones debía ejercer un papel fundamental el componente discursivo.

La Comunicación en Salud que tiene lugar en Encuentros Clínicos entre el personal sanitario —de enfermería— y las personas mayores necesitaba, pues, girar en torno a situaciones sobre TDC, EAP y PAC.

No obstante, mi ambición para con mi Tesis Doctoral fue llevarla a un nivel más allá del entorno meramente local, tal y como enmarqué la Producción I. Por ello, y para realizar una investigación integral y más completa, me decidí por escindir mi OG-TD en dos variantes:

1. Primaria y original, en la que mis ECD tomaran una dirección propia, acorde con mi inquietud ante lo desconocido y mis deseos por formarme en las nociones teórico-metodológicas de los ECD para “aprender a emprender” una investigación propia, e incorporarla a mi bagaje académico-profesional del futuro.

2. Secundaria y afianzadora, en la que complementase la dimensión de la variante original con ECD secundarios que hiciera sobre trabajos primarios cuya naturaleza temática fuese la misma.

Así, la Producción II se identificó con la vertiente secundaria del OG-TD. Sin embargo, no por ello quise renunciar a otorgarle una pincelada, una marca original, como si esta Producción II fuera un río que va a dar a los mares primario y secundario.

Fue por esa razón que en lugar de ceñirme a una revisión de la literatura actual con respecto a las situaciones de TDC, EAP y PAC, opté por realizar una síntesis de estudios cualitativos primarios, mediante la metodología propuesta por Sandelowski & Barroso, denominada meta-síntesis de estudios cualitativos primarios.

La característica principal de esta metodología reside en que, aparte de integrar y sintetizar un conjunto de estudios cualitativos primarios sobre cierta temática de estudio, se aporta además una nueva interpretación sobre dicho fenómeno estudiado (Sandelowski & Barroso, 2006)[9]. Dicha metodología, combinada con una revisión sistemática de estudios cualitativos primarios, añadiría mayor rigor y entidad a la meta-síntesis cualitativa. Fue mi decisión la de entregarme a ello.

La Producción II, pues, trató de sintetizar sistemáticamente los resultados de estudios cualitativos primarios sobre cómo las personas mayores que vivían en la comunidad experimentaban los procesos de TDC, EP/EAP y PAC, además de

[9] Sandelowski, M., & Barroso, J. (2006). *Handbook for synthesizing qualitative research*. springer publishing company.

identificar qué elementos configuraban la aparición de dichos procesos, su interrelación y cómo condicionaban las relaciones de poder establecidas entre el personal sanitario y las personas mayores.

Los resultados de la meta-síntesis perteneciente a la Producción II apuntaron hacia una relación influenciada, por parte de las personas mayores, por su autoconcepto y capacidades comunicativas; por parte del personal sanitario, por su personalidad, sus habilidades comunicativas y la concepción que tuvieran sobre el complejo constructo que daba forma al concepto de "persona mayor". Cuando existía un desequilibrio de poder entre el binomio persona mayor-personal sanitario, reproducido a través del discurso, ocurrían situaciones de discriminación por edad. La persona mayor, en tal caso, digería el edadismo confundiendo las situaciones *reales* de TDC con aquellas que no lo eran —las catalogué como *espejismos* de TDC—, inhibiendo su EP, e impidiendo la PAC. Por otro lado, el contexto situacional fue un componente que cobró gran fuerza, inclinando la balanza en ocasiones hacia un lado claramente dominante; regulando cómo los fenómenos de TDC, EP/EAP y PAC aparecían, se interrelacionaban y condicionaban el cuidado en personas mayores residentes en la comunidad.

En definitiva, la única conclusión posible a estas alturas fue entender las relaciones de poder entre personal sanitario y personas mayores en la comunidad como un fenómeno complejo y dinámico, que requería una mayor profundidad de estudio (**Figura 7**).

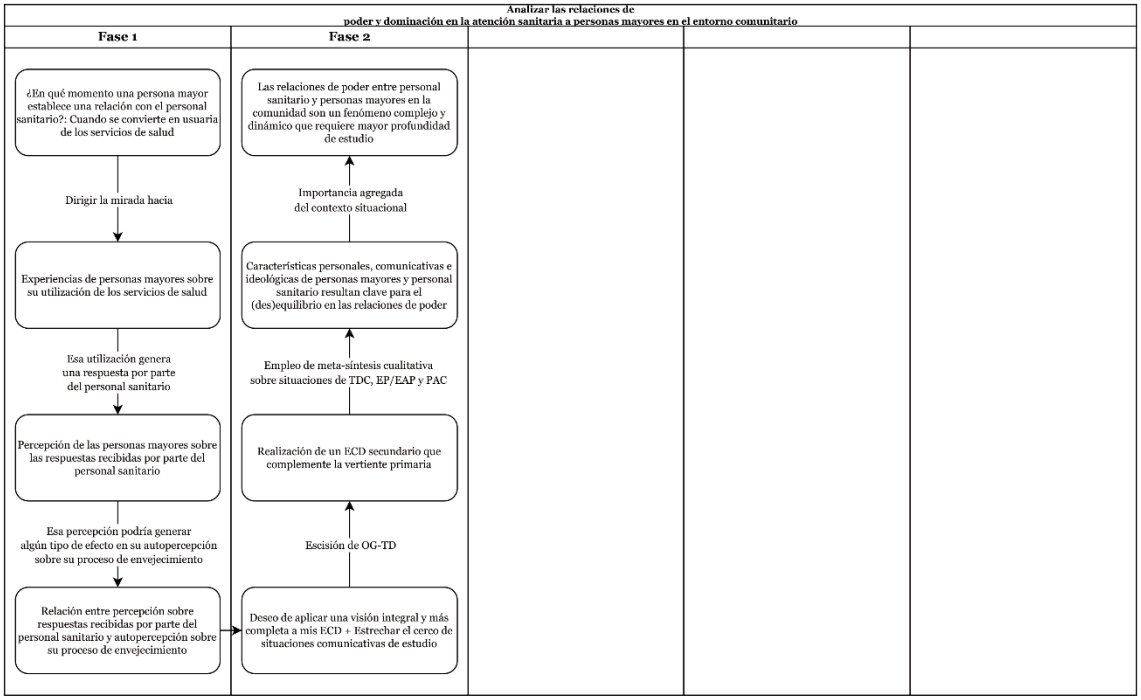

Figura 7. Hoja de ruta de la Tesis Doctoral hasta la Fase 2. Elaboración propia.

II. Integrating shared decision-making, expressing preferences, and active participation of older adults in primary care nursing: a systematic review of qualitative studies and qualitative meta-synthesis.

Title

Integrating shared decision-making, expressing preferences, and active participation of older adults in primary care nursing: a systematic review of qualitative studies and qualitative meta-synthesis.

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Estado de la Producción II con respecto a su publicación en una revista indexada en JCR (Journal Citation Reports)

Pendiente de decisión final por parte del editor.

ABSTRACT

Objectives: To systematically synthesize the results of primary qualitative studies on how community-dwelling older adults experience shared decision-making processes, express preferences, and actively participate in care.

Design: Systematic review of qualitative studies and qualitative meta-synthesis.

Methods: We focused on studies about community-dwelling participants aged ≥65 undergoing a health-disease process circumscribed to a primary healthcare setting, and the central theme should focus on either shared decision-making, expressing preferences, or patient participation. We searched the following databases: MEDLINE, CINAHL, Web of Science, Scopus, and PsycINFO (time publication frame 2012-2022). We excluded studies in those cases where the qualitative results were not analyzed or unrelated to the phenomenon addressed, phenomena were not clear enough to be included, or the setting did not occur in the community.

Results: A total of 12 studies were included in this meta-synthesis. We appraised the quality of the selected studies through CASP Checklist. The metasummary comprised the frequency and intensity of qualitative patterns across the included studies. The meta-synthesis revealed four influential elements in their interaction: Recognizing personal qualities, facing professional characteristics, experiences of discrimination, and a double-edged context.

Conclusions: The phenomena studied were influenced by how older people approached their role in their binomial relationship with healthcare professionals. Those with a reinforced self-concept were better aware of health-disease-related situations regarding shared decision-making and the importance of being communicatively assertive. Professional characteristics were also crucial

in how older people modulated their acting ability through their personality, communication skills, and the approach healthcare professionals used toward older adults. Situations of discrimination generated through an imbalance of power inhibited the expression of preferences and hindered the active participation of older people. The context surrounding the participants influenced all these situations, key in tipping the balance between a therapeutic and a harmful side.

PROSPERO registration number: CRD42022363515.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- This is the first meta-synthesis of qualitative research exploring in a joint perspective the phenomena of shared decision-making, the expression of preferences, and active participation in older people living in the community.
- The synthesis identifies core overarching elements that facilitate understanding the factors that originate, influence, and condition the phenomena of study.
- The synthesis highlights the importance of balancing power relations between older people and healthcare professionals so that real situations of shared decision-making, expression of preferences, and active participation emerge.
- Some studies constituting the synthesis have a limited methodological description, and an attempt was made to balance this by clearly and concisely organizing their data.

INTRODUCTION

In the *World report on aging and health*, the WHO stated that older people are expected to have a high use of health services due to the impact of multimorbidity on their abilities [1]. Following this statement, those health systems that care for older adults by taking their needs into account do so more effectively than those that only consider specific diseases separately as a reference in their care. Respecting older adults' autonomy and control, privacy, communication, and identity is a way of meeting their dignity needs [2,3]. Therefore, ensuring processes that manage effective and dignified primary care for older people seems crucial. However, unlike other population groups, these processes are often blurred in pursuit of an ageist conception through which older adults are considered people who, by definition, are incapable or cannot manage their care [4–6]. This ageism undermines care based on respect and inhibits the active involvement of older adults [7]. Within those effective and dignified processes that could represent a solution against ageism are shared decision-making, expressing preferences about care, and engaging in active participation [8–10].

Shared decision-making: a kind of controversial performance

Regarding the first of them, we understand shared decision-making as a process based on choice, option, and decision talk, whose steps are: a) introduce the choice, b) describe options, and c) help the patient explore their preferences and make decisions [11,12].

These shared decisions can occur in a wide range of possibilities, from those dealing with clinical issues to others choosing to stay at home [13]. However, this concept remains controversial today because older patients often

need more confidence to decide. This is hindered by insufficient or poor-quality information, adding to the issue that there are times when healthcare professionals do not include older people in the decision-making process [14]. Therefore, robust communication between healthcare professionals and the older patient and cohesive teamwork that creates an environment of security and trust are needed for this process to occur authentically and therapeutically [15].

Expressing preferences = boosting autonomy

Incorporating patient preferences when designing or organizing treatments is beneficial, according to Swift et al. [16]. Similarly, and fleeing from a merely positivist plane, listening to and introducing the preferences of patients into the modus operandi of healthcare professionals not only personalizes medical treatment and nursing care but also validates and reinforces the self-concept of the older person, in addition to giving them a role of active agency, facilitating emotional relief, and supporting their autonomy [17,18]. This process is connected to the previous one of shared decision-making because when older patients decide freely, they have previously done so based on a preference.

Active participation: a meeting point

Knowledge of the preferences of older patients and their tailoring in the decision-making process is crucial to stimulate active participation [19,20]. This active participation is considered one of the critical features for health intervention in older people to be effective, potentially alleviating even negative sensations derived from managing situations of illness [21]. The patient's participation in a health environment refers to actively collaborating in the care process with the health professional. This contribution can be performed by asking questions, expressing concerns, or expressing preferences [22]. The

patient's active participation is also considered part of patient-centered care and a requirement to conduct shared decision-making [23].

Integrating shared decision-making, expressing preferences, and active participation of older adults in primary care nursing

As the evidence has shown, these three processes are closely related and can even be interpreted as dependent on each other: to reach shared decision-making, it becomes necessary to express preferences and, in turn, deciding is already participating in some process. Integrating these phenomena can capture a deeper understanding of, on the one hand, how they interrelate and what shapes them in the case of older adults.

On the other hand, this discovery would reveal which communicative elements become essential in the health-disease process of older adults, thus helping to adapt specific decision-making approaches in primary care situations [24].

The term health-disease process refers to the sociocultural construction through which the individual experiences the moment of illness as a temporary transit that influences roles, expectations, representations, and health behaviors uniquely and dynamically [25]. Thus, realizing this study would also help develop specific approaches to handle this construct by identifying the determinants and elements that condition these experiences [26].

In this way, addressing shared decision-making, expressing preferences, and active participation in community-dwelling older adults, from the integrating approach of a qualitative meta-synthesis, may result in a new contribution to how a relationship based on respect and dignity of older adults emerge, contributing

to avoiding ageist attitudes still present on the part of healthcare professionals [27,28].

Finally, considering the roadmap set by the WHO's report for the Decade of Healthy Aging 2021–30 [29], the purpose of the present qualitative synthesis was to systematically synthesize the results of primary qualitative studies on how community-dwelling older adults experience shared decision-making processes, express preferences, and actively participate in care. In addition, we aim to synthesize what elements shape their appearance, interrelation, and how they condition the healthcare professional-older patient relationships.

METHODS

Design

Sandelowski & Barroso define qualitative research synthesis as a process and a product of scientific inquiry whose purpose is to systematically review and formally integrate the findings from completed qualitative studies [30]. Within qualitative research synthesis, there are a variety of methodological approaches. Firstly, we performed a meta-summary of effect sizes approach. We did this to obtain an empirical foundation for a subsequent qualitative meta-synthesis since we handled a collection of qualitative studies to determine the frequency and intensity of qualitative patterns intra- and across studies [30,31].

Secondly, and once we fulfilled the meta-summary of effect sizes, we conducted a qualitative meta-synthesis approach, since we analyzed qualitative data across the selected studies, thus appraising, summarizing, and combining qualitative evidence to address the research question and, therefore, offering a novel interpretation of how shared-decision making, expressing preferences, and active participation relate in the health-disease process of community-dwelling older adults [30,31]. We used a synthesizing approach linked to a reciprocal translation [30,32]. The objective of this approach was to retain the particularity of the primary results even when they are synthesized.

We then share the notion about the qualitative meta-synthesis as something more than the sum of its parts, going beyond the primary interpretations from the selected studies, thus developing new contributions. This applies to our goal to synthesize and deliver a new interpretation of how the moment of shared decision-making appears in older patients in a community setting, how this is interrelated with expressing their preferences, and how it could be translated to patient participation. In addition, we maintained an

explicit focus on contrasting and determining the elements that shaped the course of the study phenomenon [33].

Besides, we performed a systematic review of qualitative literature, which required an exhaustive approach to searching and appraising selected qualitative studies [34]. This is consistent with how Sandelowski & Barroso also understand the search process of qualitative studies [35].

The structure of this study is based on the six steps that Sandelowski & Barroso indicate to perform the meta-synthesis [35]: (a) conceiving the synthesis, (b) searching and retrieving literature, (c) appraising findings, (d) classifying findings, (e) synthesizing findings into metasummaries, and (f) synthesizing findings into a meta-synthesis.

This meta-synthesis was prepared following the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement [36] (supplementary Table 1) and the Enhancing Transparency in Reporting the Synthesis of Qualitative Research Statement [37]. In the same way, this meta-synthesis was registered in the International Register of Systematic Reviews (PROSPERO) with ID CRD42022363515.

Conceiving the synthesis

A reflection period was initiated before posing the research questions, which, throughout the meta-synthesis, would account for its circular and flexible nature [38]. This period was marked by the following moments: (1) defining the key concepts around which the qualitative synthesis should revolve, (2) deciding the perspective that will be adopted to address the phenomenon under study, (3) making sure of the challenge of establishing adequate methodological and theoretical bases for a meta-synthesis.

The research questions were:

1. "How do shared decision-making moments appear in community-dwelling older patients?"
2. "How is this interrelated with expressing their preferences?"
3. "How could it be translated to patient participation?"

Searching and retrieving literature

The qualitative studies to be included had to meet the following inclusion criteria to elucidate the focus of the meta-synthesis:

A. Participants aged ≥65, or median age ≥65 if mixed population (excluded if >25% of participants aged <60),

B. Participants were patients who were undergoing a health-disease process (acute or chronic),

C. Participants were clients of/interacted with primary health care services,

D. Original research studies conducted using qualitative methodology,

E. The central theme of the research was:[10]

a. Shared decision-making,

OR

b. Patient preferences,

OR

c. Patient participation.

The exclusion criteria were as follows:

A. Qualitative results of primary studies were not analyzed or not related to the phenomenon addressed.

B. Phenomena were not clear enough to be included.

[10] Given that these three elements are closely related, as formerly stated, the research team considered addressing them separately to meet the first of the objectives of this meta-synthesis, which is to synthesize them providing a new joint interpretation.

C. The setting did not take place in the community.

D. Seriously ill / end-of-life older participants.

We selected five databases (PubMed, CINAHL, Web of Science, Scopus, and PsycINFO). PubMed for being one of the largest databases in the field of health sciences; CINAHL, for being one of the essential nursing databases; Web of Science, for its grand scope and number of indexed articles; Scopus and PsycINFO, for their great value in the psychosocial and psychological sphere, which encompasses a series of necessary nuances in shared decision-making, patient preferences, and patient participation. We decided to use pertinent database filters further to ensure a thorough practice in the literature search, thus helping to avoid the threat of failing to achieve sufficient validity in this study [30]. The filters used in the databases are the following: (1) the last ten years because more than 80% of the studies found were performed from the year 2012, (2) nursing, to circumscribe the study phenomena to the discipline of Nursing, (3) exclude MEDLINE records, in those databases other than PubMed, and that had it available to eliminate duplicates, (4) English/Spanish because they are the languages that the research team mastered. Both the filters applied, and the search terms were adapted to the configuration of each database. We performed a comprehensive search strategy; its results can be found in the supplementary Table 2.

PMA searched MEDLINE and CINAHL on September 9th, Web of Science and PsycINFO on September 13th, and Scopus on September 15th and 16th, 2022. Finally, all databases were searched on September 22nd. This process was supported and followed by MRR, as we explain next. At the beginning of the article screening phase, consensus meetings were held to agree on each step that would be carried out. We decided to use EndNote for screening. PMA performed

all screening stages, applied the eligibility criteria mentioned above, and selected studies through a detailed review of the title, abstract, and full text for their inclusion. 10% of the selected articles were chosen randomly and sent to MRR for evaluation and to obtain feedback and check decisions made. Both authors read and reviewed all potentially relevant articles after that. All the research team agreed with the decisions and steps. Finally, 12 studies were selected for their inclusion (Figure 1).

Appraising reports

After selecting the final reports, we performed an individual and a group appraisal. It consisted of, on the one hand, reading individually as many times as necessary to identify specific content and, on the other, comparing collectively through a group meeting the studies to address differences and similarities to establish a relationship between them and create summaries, adding to develop a consensus between the content found by the authors [30].

We applied to the Critical Appraisal Skills Program (CASP), a checklist focusing on qualitative studies' findings, validity, and usefulness. The main strength of the CASP checklist resides in promoting a systematic approach by which the advantages and disadvantages of a study may be identified [39]. PMA and MRR followed the checklist grid to evaluate the 12 chosen articles. After that, they shared the results. We understood this step as more than simply scoring or fixing anything because it helps to better understand the selected studies before embarking on the findings [35].

Classifying findings

We considered the older participants of each selected study as the first-order generators of knowledge. Later, the authors of each study would be the

second-order generators of knowledge by giving the first interpretations. Finally, we occupied the third position by providing a new interpretation of the knowledge generated by the first two. For this reason, this meta-synthesis could be understood as three different levels where we are the third interpreters of the first two [30,35]. We decided then to prioritize the life experiences of the first-order generators of knowledge. However, we did not completely rule out the interpretations of the second-order generators of knowledge because they served us as referential adequacy for the new interpretation of our study [40].

We emphasized the content of the data sources when classifying the findings, but first, the research team met to reach a consensus to decide what would be considered data to include. Our final decision was to contemplate data as the quotes of the older patients (first-order generators of knowledge), considering the primary researchers' interpretations and abstractions (second-order generators of knowledge). All the data classified came from the results section of the selected studies. Considering this, we understood that our choice corresponded with databased findings [30]. Databased findings are compositions built through the analysis of extracts from interviews, observations, or documents by the second-order generators of knowledge in primary qualitative studies.

Finally, we created an extraction rubric for the occasion to approach the findings of the selected primary studies uniformly and thus systematically extract the data for subsequent analysis. PMA examined all those sets of potential findings to be included in our meta-synthesis to be extracted and MRR supervised decisions made by the first. Only the findings that answered "Yes" in all the items were integrated for the next phase.

The items that made up the rubric were the following:

1. The finding is closely related to shared-decision making/ expressing preferences/ active participation (Yes/No);

2. The finding comes directly from the first-order generators of knowledge (Yes/No);

3. The finding was analyzed by the second-order generators of knowledge (Yes/No);

4. The finding held a profound qualitative meaning which could contribute to the meta-synthesis (Yes/No).

Analysis: Synthesizing findings into metasummary and meta-synthesis

The analysis phase results were managed and processed using the QSR NVivo 12 computer software tool [41].

The qualitative metasummary of effect sizes is a quantitatively oriented aggregation of qualitative findings, whose objective is to discover the frequency and intensity with which the findings are distributed within each study and across all of them [42]. In this way, performing a metasummary allowed us to identify selected studies´ patterns and increase our study´s validity.

We did not consider the qualitative metasummary as an end but as a bridge we crossed to build the meta-synthesis. Relying on the information obtained through the metasummary, we had as a reference the selected studies´ patterns to create a new interpretation based on the new qualitative patterns synthesized in our work, thus answering the research questions we posed.

For the metasummary, we also calculated the magnitude of the effect sizes. Effect sizes address the frequency of occurrence of an experience sufficient to constitute a pattern, facilitating a further understanding of the studied phenomenon and an overview of how patterns of meaning are distributed across

studies [42,43]. We calculated inter-study frequency effect size by taking the number of individual studies that contain a specific finding and dividing it by the number of total studies in the sample. In this way, we found the representation of sub-themes across studies. We calculated intra-study intensity effect size by taking the number of studies containing at least one category belonging to each sub-theme, divided by the number of total sub-themes. Following this, we found the concentration of findings of each selected study.

The meta-synthesis is an interpretive integration of qualitative findings in primary research studies through interpretive data syntheses [30]. To achieve this, PMA individually performed analysis through the phenomenological-hermeneutical considerations proposed by Ricoeur [44] and was supported by PVP and SLQ:

In the preliminary analysis phase, the authors superficially read the included studies, obtaining a general meaning and writing a list of ideas to guide the analysis until reaching a raw explanation of the phenomenon studied.

At the first level of analysis (explanation), we selected nodes or whole units of meaning. The nodes or whole units of meaning were interpretative fragments of the first-order generators of knowledge that contained a basic meaning, an explanation, and a justification of that meaning. We established a round-trip process between the nodes and the starting categories to ensure that the interpretative thread remained linked to the participants' life experiences. We considered as starting categories the interpretations and abstractions that the second-order generators of knowledge made of the first ones. After reviewing the nodes created and the studies selected, we ensured that every unit of meaning was noticed.

At the second level (naïve comprehension), the nodes were organized according to these new categories. Once contained in them, they were regrouped by the affinity of meanings, creating codes capable of reaching greater abstraction.

At the third level (in-depth understanding), we reached a greater understanding of the phenomenon through the hermeneutic arc. The hermeneutic arch is considered the achievement of a back-and-forth process that combines the preliminary understanding of the analyzed phenomenon and the final interpretations of the data corpus, reaching the highest level of abstraction of meanings with the creation of study patterns, sub-themes, and categories.

RESULTS

The results are presented in supplementary Table 3 for the effect size metasummary and both written and Figure 2 for the meta-synthesis. On the other hand, supplementary Table 4 shows intra-studies characteristics (publication year, authors, country, aims, age of the participants, sample size, characteristics of the participants, data collection tool, data analysis employed, relevant results of importance extracted from the article), and supplementary Table 5 shows characteristics across selected studies (design, older patients´ health condition, sampling strategy, informants other than older patients, setting of data collection, field notes taken in addition to interviews, audio/visual recording, data coders, use of software, argued use of trustworthiness criteria, argued use of consolidated reporting framework).

According to CASP, the selected studies' scores were the following: 70% for one article, 75% for three articles, 80% for three articles, 85% for three articles, 90% for one article, and 95% for one article (supplementary Table 6). Although all studies scored 70% or higher, no investigation would have been excluded based solely on possible poor quality [30]. The reviewers involved in the process agreed on all article criteria and scores.

Metasummary

The present study's effect size metasummary comprised the inter-study frequency effect size and intra-study intensity effect size (supplementary Table 3).

Regarding the inter-study frequency effect size, within each sub-theme, the most prominent categories were the self-perception of the older person, the approach of the health professional, the discrimination perceived in certain

situations by the older person, and the importance of feeling safe. Likewise, regarding the intra-study intensity effect size, the sub-themes had an effect size of 92%, meaning that 11 out of the 12 studies contributed categories representing each. The authors want to state that no sub-theme was considered over or under-represented because all of them arose with strength beyond their frequency in the testimonies of the older people involved [30].

Meta-synthesis

The end of the synthesizing approach to reciprocal translation gave rise to an abstract integration of findings in the community-dwelling older adults' reports in the form of an "imbalance of power relations". This imbalance of power relations in shared decision-making, expression of preferences, and active participation among older people in the community revealed two influential pillars in their interaction: the older person-healthcare professionals' binomial and a doubled-edged context. In turn, a third pillar fluctuates based on how power relations develop between the first two, the latter being situations of discrimination suffered by older people. The experiences that delivered this synthesis were assembled into four sub-themes: recognizing personal qualities, facing professional characteristics, experiences of discrimination, and double-edged context (Figure 2).

Recognizing personal qualities

Recognizing personal qualities pertains to the capacity of older people to assume those interiorized values, attitudes, beliefs, and qualities. This assumption acts: a) as an initiator of an active intention to embark on their health-disease process, leading them to have an empowered agency to decide or, at least, take part in some way in the decisions that are made around their state

of health or b) hindering that intention, attending to a kind of self-sabotage regarding enjoying opportunities that allow them to decide, express their preferences or participate.

Considering the first of the two conceptions presented in the previous paragraph, the qualities facilitated personal characteristics in achieving truly centered care for the older patient [45]. These characteristics play a vital role in older people as an anchoring point for displaying concepts they identify as a bridge between the active-attitude *self* and the active-agency *self*. That bridge is built based on inner strength, positive attitudes, and a sense of humor: “I have been an active woman my entire life, so I decided that I should learn to walk again! I followed a training program every day; eventually, I made it.” [45 p575].

As older people crossed that bridge, they realized that effective and shared decision-making is a true reflection of having autonomy in the process, which, added to the performance of that autonomy, creates participation that leads to a feeling of responsibility. Therefore, being responsible for their health increases self-identity, self-esteem, and confidence in older people, which is closely reflected in the execution of shared decision-making [46]. All of this generates a sense of control and power in older adults. This sense occurs because they also protect empowerment by safeguarding the autonomy-decision-making binomial. They expressed their preferences autonomously and powerfully in this situation: "I think it's a control issue with me.... I manage my medical care and everything else in my life and I keep [my children] in the loop after it's done." [55 p1495].
The consequences of feeling responsible also affect active participation, which, in turn, is fed back with the self-perception of that active role in their care, which increases the satisfaction that once again increases their desire to participate in a kind of therapeutic circle [8,47]. This desire to participate was also considered a

willingness to be fully informed and that this information should be based on evidence. In this way, older people declared that being fully informed is being prepared to face any process [45,48].

Older people reported that being active in their daily lives and carrying out activities is also a way of making decisions, maintaining their coping skills, and attending to their spiritual sphere [45,46]. Therefore, they highlighted having that self-perception of their needs and communicative assertiveness to express their preferences in managing their care: "You have to be assertive. I don't feel that I have to be overly assertive, because my doctor responds to my feelings. But it's important to be assertive." [52 p6].

Furthermore, personal qualities can act simultaneously as hindrances. Excessive politeness or stubborn behavior leading to unrealistic goals interferes with the decision-making process, expression of preferences, and therefore active participation, in turn, also interacts with professionals and their characteristics: “It is not always easy to give one's opinion; often a lot should happen before I do so. For instance, I feel it is rude to express my opinion about the nurse whose behavior I do not approve, that would not be appropriate. I guess I should not tell this to you, either, but…” [45 p575].

Facing professional characteristics

Facing professional characteristics pertains to all those requirements constituting healthcare, where numerous elements come together from the point of view of older persons. Professional characteristics were vital to decision-making, expression of preferences, and active participation. Healthcare professionals modulated these characteristics by having the opportunity to create situations to develop older people as active agents in care.

This relationship must be built from a mutual understanding that makes decision-making a shared act, establishing a personal interrelationship that allows an individualized approach to care for older adults [48,49]. Within this approach, giving a choice was raised as essential to promote patient involvement in decision-making: “Certainly my GP [General Practitioner] always makes me decide, you know, “What would you like to do?” Well, I don’t know, and I have sat there and said to him, “I don’t know, what would you suggest?” [...] Sometimes I don’t want to know what’s happening for an operation or something you know. He never pushed the line. It was up to you, you had to … He couldn’t make my mind up, but he could advise me, which he did.” [47 p711].

Regarding expressing preferences, older people appreciated the flexibility and availability of those healthcare professionals who made efforts to listen to their priorities regarding the day and time of home visits or the mere fact of being there when they were needed: “Sometimes, I cannot reach the toilet in time. I always have my mobile phone in my pocket, and I call the home care nurses immediately. Then they show up in a short time to help undress me and give me shower. This means a lot to me.” [45 p574].

The personality of the healthcare professionals played an essential role in bringing the older person closer to a *real* moment of shared decision-making, who highlighted honesty, kindness, understanding, and respect as critical qualities [45,48]. In short, older people positively valued those professionals who treated them not as someone who depended on their clinical judgment but as “equals”: "I feel more as an equal than I ever used to, and that helps me to have a sensible, constructive conversation with him. I think being asked to contribute treats you as a person with your own views and the ability to make that decision

for yourself [...] but also to realise that I use them to help me with my health care." [47 p713].

However, to achieve the status of "equal", older people considered it necessary to deal with professionals whose communication skills would encourage them to feel heard and to be actively involved in their care. Hence, communicative and active listening skills promote a communicative relationship centered on the older patient [47,49,50]. This added to a less paternalistic attitude on the part of the healthcare professionals, enhanced communication by the preferences of older people: ""Today we expect an awful lot more out of the health service than when I had my children 40 years ago. But I think one's attitude changes; you have a better overall view. The more you're involved, the more you see what a vast and overwhelming organization it is. You just hope they're getting it right. [...] The sort of hierarchy of the medical profession was very different, wasn't it, and they very much made the decisions for you." [47 p712].

Experiences of discrimination

Experiences of discrimination pertain to the encounter between certain personal qualities of older adults and characteristics of the healthcare professionals that caused, on certain occasions, situations of discrimination. Thus, an imbalance in their relationship originated "illusions" of moments of agency, perceptions of ageist attitudes, and even fear or dread.

These "illusions" were well exemplified when healthcare professionals made older people see that they could decide when they did not. Older people declared that they felt this delusion when professionals made decisions for them rather than together with them when handling a considerable amount of overly technical information. This gave the older patients the feeling that they could only make a decision when it was explicitly communicated to them [8,51].

Communication barriers, sustained by a lack of encouragement to listen to the concerns of older patients or to satisfy their communication needs [52,53], could be overcome if healthcare professionals had given older people a real opportunity to participate by making decisions about their possible illnesses and treatment: “No, nobody asked what I felt about being discharged. I did not protest the decision at the time. But, thinking back now, I would like to protest it because I did not feel safe enough at the time.” [45 p574]. This is a dead end where professionals did not show enough transparency. Older people considered them as power figures whom they were not able to question: "I don't want to do that [discuss reducing medication] because then I disregard my GP’s advice, my GP expects me to follow her advice” [54 p4].

This power imbalance caused older people to fear when they came up with situations in which they "challenged" that authority [51,54]. The fear of expressing their preferences due to a possible unwanted consequence and becoming responsible for their own decisions inhibited a balanced and therapeutic relationship: "I am not going to be stubborn because if something would happen, it would be my own fault." [54 p4].

The circumstances raised the older person’s perception of being treated differently due to several factors, such as age —ageism—, ethnic identity, socioeconomic condition, health condition, or language [48,51,52,54]. For this reason, healthcare professionals showed no confidence in older patients when it came to involving them in the discussion of decisions related to their health [48]; older adults were considered as people who, due to aging, were marked by disease and symptoms, something that prevented professionals from contextualizing the older people´s health condition in their life stage: "Sometimes I feel that they

think you are still a young guy because you have to reach certain [blood pressure] levels, which might not be relevant anymore for older people." [54 p4].

On the one hand, the professionals were not transparent when dealing with individual cases because they were not crystal clear about the consequences of the choices that could be made, generating a moment of uncertainty [51,54]. On the other hand, this created in older adults a feeling of dependency on the professional, coming to feel objectified, invisible, and undervalued; coming to not feel like an active agent of their own care, accepting paternalistic attitudes from the health system [51,53,54]. Such context, which created communication barriers, decreased the participation of older adults: "It's so hard to get them to pay any attention to you. They don't listen to what you're saying. 'You're an old lady and, tada, tada, tada'—you know?" [8 p225].

Double-edged context

Double-edged context pertains to a scenario that played a crucial role when calibrating personal qualities and professional characteristics, even going so far as to shape the appearance of discriminatory situations. This scenario gained importance to provide older people with positive tools to reinforce concepts that drove them to decide, express themselves and participate effectively or to deprive them of any potential opportunity to develop on that level. Depending on the older person's circumstances, everything would indicate therapeutic performance in the healthcare professional-older patient relationship or a frustrated one.

In these terms, a poor health system organization had great importance, according to older adults. The overload of work resulted in healthcare professionals always being in a hurry. In addition, there was a lack of longitudinal care; therefore, older people did not feel a continuous personalized approach

because, once and again, they were attended to by different professionals each time they used the health system [45,48,52]. This excessive workload brought significant problems with time available to be optimally attended. The fact that healthcare professionals did not dedicate the time that the older people considered necessary prevented them from having a good conversation, feeling that they lacked the opportunity to "open up", thus interfering in expressing their preferences [45,48,53]. This situation led older people to feel not like a person but like a number: "Some practicing doctors have a tendency to get into a routine of you being a number." [52 p5]. Something like this prevented the development of relationships of trust with the professionals that would shed some light on this frustrating reality [49,53].

The conducts, behaviors, and ideologies have their raison d'être in society and culture, which immediately affected how the relationships between the healthcare professional and the older patient were established. This is something that older people also made explicit through differences in approach depending on the nature of the patients, the way healthcare professionals addressed them, and how professionals managed that relationship [47,52,53]. In line with the way to manage these relationships, management and the importance of information gained prominence, being able to act as a facilitator or hinderer of the context of the relationship with professionals in older people [8,48,53,54]. The more quality information adapted to the older adult was provided considering the first possibility, the greater the engagement had in their care. Nevertheless, the problems came when the information was inconsistent between professionals, confusing older adults by providing conflicting information: “Then I asked for info [about the pneumococcal vaccine] and the practice nurse said it has been around for years but the hospital doctor said it was new.” [53 p37]. The older

people declared in any case that when they came across professionals who did not provide them with enough quality information, it led to an inability to act, which added to a feeling of not being listened to. It gave rise to the older person's disempowerment: “I like to have lots of options in front of me so that I know I can make an informed decision. But I don’t feel like that way when I go to the doctor, I feel dis-empowered.” [48 p3].

Something that favored empowerment in the decision-making process and facilitated assertive communication in the older person was surrounding themselves with a circle of trust or important ones who supported them at decisive moments [52,55]. In other words, having social support from family or friends represented a valuable tool for the relationships with healthcare professionals and the use of the health system: "My husband is taking care of me and he helps me a lot. Without him, I would need a lot more help from the healthcare services.” [45 p575].

Finally, all these elements could be found in the sense of security that combined receiving help when needed, being duly informed of their rights as clients of the health system, or dealing with professionals and flexible routines in a continuous and non-sporadic manner. The older patients also highlighted the figure of the home care nurse as a link between various levels of healthcare [45].

DISCUSSION

This systematic review of qualitative studies and qualitative meta-synthesis comprises 12 primary qualitative studies. It provides a comprehensive understanding of how the moment of shared decision-making appears in older patients in a community setting, how this is interrelated with expressing their preferences, and how it could be translated to patient participation. Our results are consistent with the theory of Van Dijk [56] of discourse and power because our meta-synthesis reveals that these three study phenomena are affected to a great extent by an (im)balance in the power relations established between the older person and the healthcare professionals. The personal qualities, professional characteristics, and the context in which they occur shape the appearance of *real* situations of decision-making, expressing preferences, and active participation; their interrelation and how they condition to care for the older patient. The reproduction of the participants' discourse of primary studies suggests that older adults' feelings of frustration and of not being heard in situations sensitive to ageism and abuse of power from the health system and the importance of a context influencing all the above could be highlighted on occasions. The shared decision-making experience, the expression of care preferences, and active participation within it are highly complex interweaving that follows communicative, relational, and personal patterns.

Discussion of findings

In general terms, older people revealed numerous elements influencing the appearance of *real* situations of shared decision-making, expressing preferences, and active participation. Our results suggest that *real* shared decision-making situations are not reduced to specific moments or issues. Still,

real situations of shared decision-making comprise the perceived feeling by older people as empowered, having control over one particular situation, and asserting their autonomy. All this is potentially enhanced by professional characteristics that care providers have and might benefit that feeling perceived by older patients. This is consistent with a recent study by Egan et al. [57] that places primary care nurses as crucial elements in enhancing the performance of older people in decision-making processes. However, as we also reflected in the results of our study, implementing shared decision making in older people is challenging [58].

Sometimes, older people did not commit to shared decision-making due to their way of being or conceiving the relationship with their reference healthcare professional. Those healthcare professionals who did not understand older people, added to a changing context, weighed down potential therapeutic relationships. According to our findings, this represented an interference with the care that could have been perfectly avoidable. This result is supported by other reviews that highlight the interrelation of elements such as the patient, the patient-healthcare professional relationship, the organization of the health system, or the importance of teamwork in a therapeutic performance that allows engaging and promoting the involvement of the patients [59–61]. The interest and "desire to do" become critical elements in the personal qualities of older people that mean a beginning to establish that therapeutic relationship, as reported by Gillespie et al. [62].

However, as explained throughout the study, personal qualities are not the only factors to consider. Regarding healthcare professionals, the meta-synthesis performed by Clancy et al. [2] determined the importance of establishing positive relationships with older people. This is consistent with our study because older

patients appreciated dealing with healthcare professionals who allowed them to express their feelings and preferences. In addition, professional characteristics such as having confidence and the ability to control emotions are critical concepts for a promising approach in the healthcare professional-patient relationship [63].

From Van Dijk's theoretical perspective on discourse and power, our study results are consistent with his conception of communication as inequality reproducing element [56,64]. It adds to understanding how the phenomena studied are interrelated, degenerating into situations of discrimination when the discourse serves as a vehicle for the dominating elements. This result is consistent with other reviews that displace older people to a passive role on numerous occasions, endangering the balance of power between them and healthcare professionals and highlighting the discourse as a power-holding tool [65,66]. This tool can feed the feeling of living in a *mirage* of opportunities. For older patients, this *mirage* translates into a lack of opportunities to participate in care, despite feeling motivated, in a kind of imbalance of power between the healthcare professionals and the older patients where communication has an essential role, as Ozavci et al. [67] showed in their systematic review. Ageism situations appear when the characteristics of the disease are confused with a physiological stage, such as the aging process. These results are consistent with the Stereotype Embodiment Theory, which explains an internalization of ageism in society, thus unconsciously acquiring stereotypes due to ageist messages that society itself sends through the institutions, in this case, the healthcare system [68]. From the perspective of ageism and compared with other reviews about young adults, elements such as communication and information delivery in decision-making are equally important [69,70]. However, although similar needs are shared in both populations, older people deal with ageist attitudes on the part of society, as

our results have shown, in addition to a scarcity of studies focusing on how to empower older people in transitional decision-making processes [71]. For this reason, when healthcare professionals adopt ageist behaviors, they limit the possibility of older people developing and expressing themselves as active agents of change, creating a marginalization based on these unbalanced power relations [72]. In contrast, based on our study, we meet the qualitative synthesis of Strandås & Bondas [73] when a more therapeutic nurse-patient relationship has been managed to demonstrate that it promotes communicative openness and a boost to positive sensations; in other words, to share moments of accessibility in care.

The importance of a context that can be positive or negative for the appearance of *real* situations of shared decision-making, expression of preferences, and active participation in older people has become apparent. The fact that nurses and doctors have little time to care for patients, in addition to an excessive workload, blames a deficient organization of the health system in a certain way, thus negatively impacting in quality of care and professional performance, being consistent with other reviews [74,75]. Furthermore, positive social support in older people facilitates dealing with hostile situations and reinforces their communicative assertiveness, communicating their preferences more frequently [76,77]. The feeling of security in this study appeared along with other closely related concepts, such as the importance of receiving adequate and personalized information and the confidence that healthcare professionals knew how to transfer them. Regarding this feeling of safety, older people also stated that the possibility of continuing their recreational or spiritual activities in the community comforted them and prevented feelings of loneliness or isolation, thus consistent with the scoping review conducted by Fakoya et al. [78].

Strengths and limitations

The main strength of the present study is that it represents the first qualitative meta-synthesis that gives greater depth to understanding the phenomena of shared decision-making, the expression of preferences, and active participation in community-dwelling older adults, jointly and not separately. The new interpretation offered by this study has highlighted the importance of power relations in triggering situations of ageism regarding the studied phenomena. Thus, our meta-synthesis underlines elements that healthcare professionals could consider incorporating into their daily practice and thus promote a therapeutic relationship of *real* situations of shared decision-making, expression of preferences, and active participation in nursing care. Assuming mental conditions could also have enriched the study. However, this was discarded because we considered older patients with mental impairment to be another type of group with very particular characteristics that could influence the phenomena studied, compared to older people without any cognitive impairment. In addition, the number of articles selected (n = 12) for the present study can be interpreted as low compared to the studies considered for screening before title review (n = 785). To justify this, a critical review of the articles found that a large majority of the articles did not reach the necessary depth in the study of any of the inclusion phenomena, either because they did not provide detailed information regarding the phenomenon development in the older patient, or for being listed as one more intervention to be studied without enjoying the prominence the study required to be incorporated. Due to language issues, interesting investigations may have been lost by handling only English and Spanish. This meta-synthesis includes studies from Europe, America, and Australia, providing a broad perspective that, in turn, is a window to the peculiarities between the different cultures, how the study

phenomena arise, and how power relations are established in the process. By including studies from Asia and Africa that could have passed the eligibility filter, we would have understood these similarities and variations from a global perspective. Focusing this study on the nursing field could be considered a limitation. However, we thought it necessary since there is little evidence of the inclusion and importance of the nursing figure in these processes, particularly in decision-making, which hardly exists in conceptual models of interprofessional shared decision-making [69]. For this reason, this study broadens the depth of the phenomena studied in a discipline that is only sometimes integrated into them. Our decision not to exclude studies because of limited descriptions of methods may be questioned. However, we strive to distribute the data and findings relatively evenly by sub-themes (supplementary Table 3) to strengthen the validity of the results beyond the methodological quality of the primary studies [30,35]. Furthermore, one of the issues in qualitative profile studies is that the relationships between the participants and the researchers may have influenced the findings they obtained. However, this has enriched their nuance and adjusted to the particularity of shared decision-making situations, expressing preferences and active participation of older people and giving extra complexity to the depth of each study. Moreover, the researchers' knowledge and relationship with the participants may have been crucial for recruiting key participants and their subsequent data collection. In addition, the reflections made by the researchers could have increased the validity of the studies. Lastly, even though the methodology used in this study prevents the participation of older people, it becomes necessary to continue qualitative research that addresses this complex phenomenon that we have integrated.

CONCLUSIONS

This meta-synthesis is based on previous studies revealing the implicit complexity in shared decision-making situations, expressing preferences, and active participation of community-dwelling older adults. These phenomena are influenced by how older people approach their role in their binomial relationship with healthcare professionals. Those with a reinforced self-concept know that their personality has traits that make them face health-disease-related situations effectively and be communicatively assertive. In contrast, others with specific profiles make them lose sight of their potentially essential role in "taking care of themselves". Healthcare professional characteristics are vital in how older people modulate their acting ability. Their personality, their communication skills, and the type of approach healthcare professionals use toward older adults are what this study has reflected. The study phenomena are distorted due to how older people and healthcare professionals relate. When there is an imbalance of power between the two, reproduced through the discourse in those cases in which the relationship is not therapeutic, it causes situations of ageism. Then, the older person can perceive discrimination, differentiating the shared decision-making situations from those that are not (mirages), inhibiting the expression of their preferences, and preventing them from participating in their care. The context is a component that rose strongly, tipping the balance from one therapeutic side to another of *domination*, and vice versa, regulating how the study phenomena appear, interrelate, and condition care in community-dwelling older adults. Regarding implications for future research and clinical practice, the great asset of this study is to offer a joint vision of the phenomena studied, allowing, on the one hand, favoring more integrative research and, on the other, making visible the

care of the three elements to create new nursing-based interventions that act by synthesizing them.

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Tables, Figures and Supplementary Material

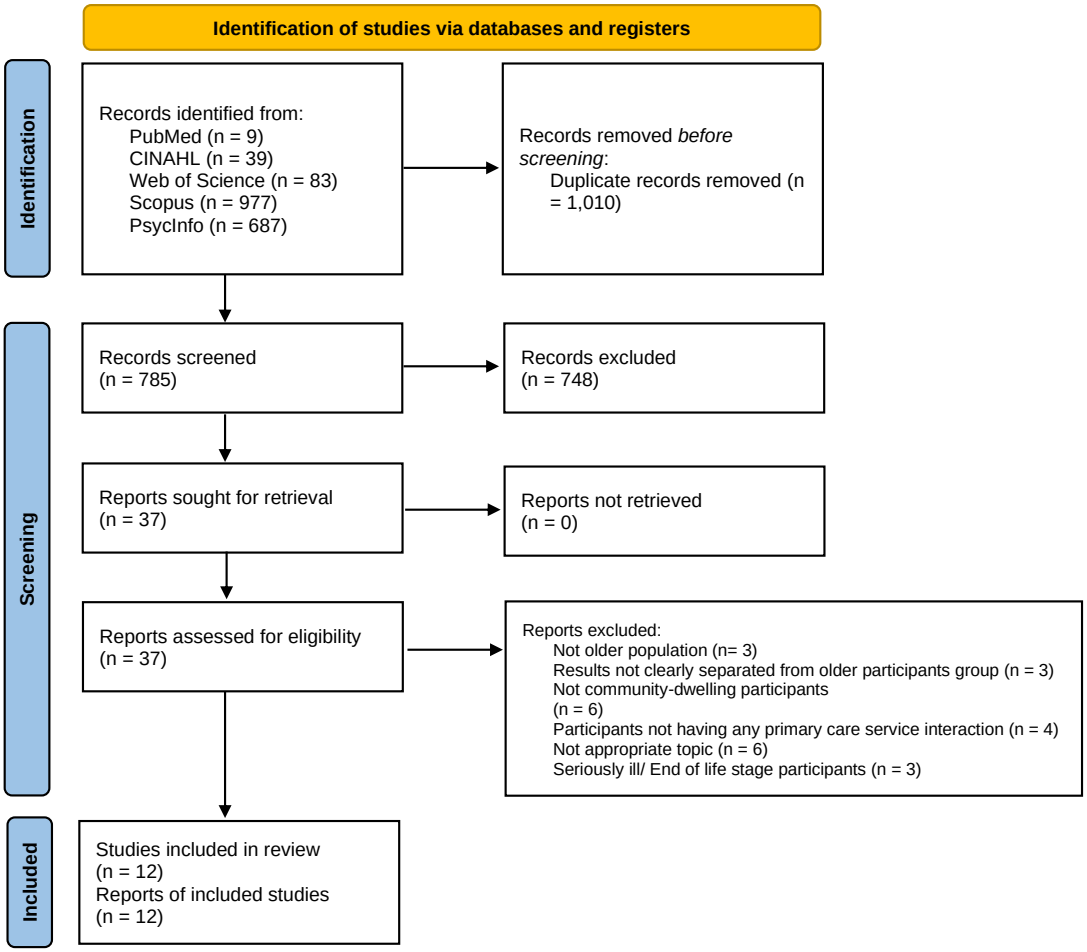

Figure 1. PRISMA 2020 statement flow diagram.

Table S1. Checklist of items to include when reporting a systematic review or meta-analysis.

Section/topic	*#*	*Checklist item*	*Reported on page #*
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	1
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	1, 2
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	2, 3, 5
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	4
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	6, 7

Section/topic	*#*	*Checklist item*	*Reported on page #*
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	6, 7
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	7
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	7
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	7, 8, 9
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	7, 8
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	7
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	7, 8, 9
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	8, 9

Section/topic	*#*	*Checklist item*	*Reported on page #*
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	7
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	8, 9
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	7
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	10
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome-level assessment (see Item 12).	7
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group and (b) effect estimates and confidence intervals, ideally with a forest plot.	Not applicable
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	10-16
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	7

Section/topic	*#*	*Checklist item*	*Reported on page #*
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	10
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., health care providers, users, and policy makers).	17-19
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias).	19, 20
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	21
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	21

Database	Query no.	Search strategy	Results
PUBMED	#1	((((“decision making, shared”[Majr]) OR (“shared decision making”[Title/Abstract])) OR (“shared decision-making”[Title/Abstract])) OR (“mutual decision making”[Title/Abstract])) OR (“mutual decision-making”[Title/Abstract])	
	#2	((((“patient preference”[Majr]) OR (“patient preferences”[Title/Abstract])) OR (“preferences, patient”[Title/Abstract])) OR (“preference, patients”[Title/Abstract])) OR (“preferences, patients”[Title/Abstract])	
	#3	(((((“patient participation”[Majr]) OR (“engagement, patient”[Title/Abstract])) OR (“patient engagement”[Title/Abstract])) OR (“involvement, patient”[Title/Abstract])) OR (“patient involvement”[Title/Abstract]))	
	#4	(((((((“aged”[Majr:NoExp]) OR (“aged, 80 and over”[Majr:NoExp])) OR (elder*[Title/Abstract])) OR (“elderly people”[Title/Abstract])) OR (“older”[Title/Abstract])) OR (“older people”[Title/Abstract])) OR (“old people”[Title/Abstract])) OR (old adult*[Title/Abstract])) OR (older adult*[Title/Abstract])	
	#5	(((((“qualitative research”[MeSH Terms]) OR (“focus groups”[MeSH Terms])) OR (“qualitative methods”[Title/Abstract])) OR (“qualitative study”[Title/Abstract])) OR (“interview”[Title/Abstract])) OR (“experience”[Title/Abstract])	
	#6	((#1 OR #2 OR #3) AND #4 AND #5) AND (nursing [sh])	
		Filters applied: Last 10 years; Nursing[subheading]; English; Spanish.	**9**

CINAHL	#1	MM (“decision making, shared”) OR TI (“shared decision making” OR “shared decision-making” OR “mutual decision making” OR “mutual decision-making”) OR AB (“shared decision making” OR “shared decision-making” OR “mutual decision making” OR “mutual decision-making”)	
	#2	MM (“patient preference”) OR TI (“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”) OR AB (“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”)	
	#3	MM (“patient participation”) OR TI (“engagement, patient” OR “patient engagement” OR “involvement, patient” OR “patient involvement”) OR AB (“engagement, patient” OR “patient engagement” OR “involvement, patient” OR “patient involvement”)	
	#4	MM (“aged” OR “aged, 80 and over”) OR TI (“elder” OR “elders” OR “elderly” OR “elderly people” OR “older” OR “older people” OR “old people” OR “old adult” OR “old adults” OR “older adult” OR “older adults”) OR AB (“elder” OR “elders” OR “elderly” OR “elderly people” OR “older” OR “older people” OR “old people” OR “old adult” OR “old adults” OR “older adult” OR “older adults”)	
	#5	MH (“qualitative research” OR “focus groups” OR “qualitative methods” OR “qualitative study” OR “interview” OR “experience”) OR TI (“qualitative research” OR “focus groups” OR “qualitative methods” OR “qualitative study” OR “interview” OR “experience”) OR AB (“qualitative research” OR “focus groups” OR “qualitative methods” OR “qualitative study” OR “interview” OR “experience”)	
	#6	(#1 OR #2 OR #3) AND #4 AND #5	

		Filters applied: Last 10 years; Articles; Nursing; Exclude MEDLINE records; English; Spanish.	**39**
WEB OF SCIENCE	#1	TS=(“decision making, shared” OR “shared decision making” OR “shared decision-making” OR “mutual decision making” OR “mutual decision-making”)	
	#2	TS=(“patient preference” OR “patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”)	
	#3	TS=(“patient participation” OR “engagement, patient” OR “patient engagement” OR “involvement, patient” OR “patient involvement”)	
	#4	TS=(“aged” OR “aged, 80 and over” OR “elder” OR “elders” OR “elderly” OR “elderly people” OR “older” OR “older people” OR “old people” OR “old adult” OR “old adults” OR “older adult” OR “older adults”)	
	#5	TS=(“qualitative research” OR “focus groups” OR “qualitative methods” OR “qualitative study” OR “interview” OR “experience”)	
	#6	(#1 OR #2 OR #3) AND #4 AND #5	
		Filters applied: Last 10 years; Articles; Nursing; English; Spanish.	**83**
	#1	INDEXTERMS (“decision making, shared”) OR TITLE-ABS-KEY (“shared decision making” OR “shared decision-making” OR “mutual decision making” OR “mutual decision-making”)	
	#2	INDEXTERMS (“patient preference”) OR TITLE-ABS-KEY (“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”)	

SCOPUS	#3	INDEXTERMS (“patient participation”) OR TITLE-ABS-KEY (“engagement, patient” OR “patient engagement” OR “involvement, patient” OR “patient involvement”)	
	#4	INDEXTERMS (“aged” OR “aged, 80 and over”) OR TITLE-ABS-KEY (“elder” OR “elders” OR “elderly” OR “elderly people” OR “older” OR “older people” OR “old people” OR “old adult” OR “old adults” OR “older adult” OR “older adults”)	
	#5	TITLE-ABS-KEY (“qualitative research” OR “focus groups” OR “qualitative methods” OR “qualitative study” OR “interview” OR “experience”)	
	#6	(#1 OR #2 OR #3) AND #4 AND #5	
		Filters applied: Last 10 years; Articles; Nursing; English; Spanish.	**977**
	#1	mjsub("decision making, shared") OR ti("shared decision making" OR "shared decision-making" OR "mutual decision making" OR "mutual decision-making") OR ab("shared decision making" OR "shared decision-making" OR "mutual decision making" OR "mutual decision-making") OR if("shared decision making" OR "shared decision-making" OR "mutual decision making" OR "mutual decision-making")	
	#2	mjsub(“patient preference”) OR ti(“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”) OR ab(“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”) OR if(“patient preferences” OR “preferences, patient” OR “preference, patients” OR “preferences, patients”)	
	#3	mjsub(“patient participation”) OR ti(“engagement, patient” OR “patient engagement” OR “involvement, patient” OR “patient involvement”) OR ab(“engagement, patient” OR “patient	

		engagement" OR "involvement, patient" OR "patient involvement") OR if("engagement, patient" OR "patient engagement" OR "involvement, patient" OR "patient involvement")	
PSYCINFO	#4	mjsub("aged" OR "aged, 80 and over") OR ti("elder" OR "elders" OR "elderly" OR "elderly people" OR "older" OR "older people" OR "old people" OR "old adult" OR "old adults" OR "older adult" OR "older adults") OR ab("elder" OR "elders" OR "elderly" OR "elderly people" OR "older" OR "older people" OR "old people" OR "old adult" OR "old adults" OR "older adult" OR "older adults") OR if("elder" OR "elders" OR "elderly" OR "elderly people" OR "older" OR "older people" OR "old people" OR "old adult" OR "old adults" OR "older adult" OR "older adults")	
	#5	ti("qualitative research" OR "focus groups" OR "qualitative methods" OR "qualitative study" OR "interview" OR "experience") OR ab("qualitative research" OR "focus groups" OR "qualitative methods" OR "qualitative study" OR "interview" OR "experience") OR if("qualitative research" OR "focus groups" OR "qualitative methods" OR "qualitative study" OR "interview" OR "experience")	
	#6	(#1 OR #2 OR #3) AND #4 AND #5	
		Filters applied: Last 10 years; English; Spanish.	**687**

Table S2: Complete search strategy and filters applied for the meta-synthesis

									and controlled patient participation when patients responded to ascribed goals formulated by the health worker. The findings highlight that patients' share in communication should be taken more into account than what is found. Dialogue where the health staff asked both open and clarifying questions and showed skills in active listening motivated patient participation
P7	2015	Crotty BH et al./USA	To identify how patients older than 75 years wished to share their health information with their caregivers and to understand how elders and families approached the spectrum of information sharing and control	75-86+ (Unknown)	30 (26/4)	Asian (n = 1) White (n = 29) High education (n = 23) Middle education (n = 5) Primary education (n = 2)	Focus group interview	Immersion/ crystallization technique through an iterative process	The more independent elder participants had difficulty picturing themselves losing control of their decision-making capabilities and having to rely on their children. Throughout discussions, elders acknowledged the importance of keeping a sense of control of their health care and decision-making. Elders expressed a level of certainty in their decision-making abilities and did not want their family to hinder their sense of control. Control exerted regarding health information depended on the context of an elder's age and health status. Elders acknowledged that sharing all parts of their health information would be important during an emergency but would not be necessary or ideal daily. Elderly participants recognized that health information and decision-making are more likely to be shared as they age or as health issues arise
P8	2015	Hedman M et al./Sweden	To describe the meaning of autonomy and participation among older people living with chronic illness in accordance with their lived experience	65-84 (Unknown)	16 (7/9)	Urban setting (n = 10) Rural setting (n = 6) Living alone at home (n = 7) Living with another person at home (n = 9)	Semi-structured individual interview	Giorgi´s (2009) descriptive phenomenological psychological method	The meaning of autonomy and participation emerged when it was challenged and evoked emotional considerations of the lived experience of having a chronic illness. The meaning of autonomy and participation was living a life apart, yet still being someone able as an older person living with chronic illness. The meaning of autonomy and participation was still being trustworthy and being given responsibility The meaning of autonomy and participation was being seen and acknowledged

Supplementary Table 3. Effect size metasummary.

Comprehensive theme	"The imbalance in power relations" promotes a mismatch between the assumption of personal qualities, professional characteristics, and a double-edged context, which can create experiences of discrimination in the elderly																**Intrastudy intensity effect size**
Sub-theme	Recognizing personal qualities			Facing professional characteristics			Experiences of discrimination			Double-edged context							
Categories	Attitude	Desire to do	Self-perception	Communicative skills	Personality	Approach	Real opportunity ?	Fear	Perceived discrimination	Feeling of safety	Social support	Time pressure	Importance of information	Trust	Society & Culture	Healthcare system organization	Individual studies´ contribution to sub-themes
Brown EL et al., 2022	X	X	X		X	X			X				X	X		X	100% (4 out of 4)
Nilsen ER et al., 2021	X	X	X	X	X	X	X			X	X	X	X			X	100% (4 out of 4)
van Bussel E et al., 2019	X		X	X		X	X	X	X	X			X	X			100% (4 out of 4)
Mitchell J et al., 2019			X	X		X			X	X	X	X			X		100% (4 out of 4)
Doekhie KD et al., 2018	X		X			X	X	X	X				X				100% (4 out of 4)
Moe A et al., 2017	X	X		X		X	X			X				X			100% (4 out of 4)
Crotty BH et al., 2015	X	X	X				X			X	X		X	X			75% (3 out of 4)
Hedman M et al., 2015	X	X	X			X	X		X	X	X			X		X	100% (4 out of 4)
Butterworth JE et al., 2014	X	X	X	X	X	X			X	X		X	X	X	X	X	100% (4 out of 4)
Beverly EA et al., 2014		X	X	X	X	X			X	X				X			100% (4 out of 4)
Bynum JPW et al., 2014	X	X	X	X		X	X		X				X				100% (4 out of 4)
Sheridan NF et al., 2012			X	X	X	X			X	X	X	X	X	X	X		100% (4 out of 4)
Interstudy frequency effect size Representation of sub-themes in individual studies	75% (9 out of 12)	67% (8 out of 12)	92% (11 out of 12)	67% (8 out of 12)	42% (5 out of 12)	92% (11 out of 12)	58% (7 out of 12)	17% (2 out of 12)	75% (9 out of 12)	75% (9 out of 12)	42% (5 out of 12)	34% (4 out of 12)	67% (8 out of 12)	67% (8 out of 12)	25% (3 out of 12)	34% (4 out of 12)	

P4	2019	Mitchell J et al./USA	To provide missing details on older African American men's first-hand experiences with primary care communication and participation, including their perceptions on how patient–provider communication, physician behaviors, and other health system factors influence the quality of their care	Unknown (65,9)	15 (0/15)	High education (n = 11) Primary education (n = 3) Retired (n = 10) Disabled (n = 1) With full or part-time employment (n = 4)	Semi-structured individual interviews conducted by phone	Thematic analysis	Two of the primary themes identified, perceptions of rushed care and racial or ethnic bias in care and communication, focused on important reasons for dissatisfaction with the primary care health experience. The theme regarding companions as a source of support highlighted how older African American men in the study viewed and valued the contributions of their significant others who accompanied them on medical visits. The final theme concerning participants' confidence, assertiveness, and self-advocacy, revealed the salience of men's self-perceptions and demonstrated how men in the study felt fully capable of speaking up for themselves during healthcare interactions
P5	2018	Doekhie KD et al./Netherlands	To openly explore the perspectives of patients, informal caregivers and primary care professionals on patient involvement in the decision-making process in primary care team interactions	62-98 (81,6)	19 (15/4)	With ≥2 chronic conditions (n = 18) With <2 chronic conditions (n = 1)	Semi-structured individual interview	Content analysis	Some patients feel limited in taking on an active role because of their interactions with professionals. They feel treated like passive bystanders in their own care process and that the professionals make decisions for them instead of with them. These patients want to be actively involved and feel obliged to express this explicitly. Other patients want to express their own opinions and wishes but hesitate to do so because of possible negative reactions. Patients sometimes feel that professionals do not always value their opinion, while in some situations, they feel they know best
P6	2017	Moe A et al./Norway	To gain knowledge about conversation processes and patient influence in formulating the patients' goals	67-90 (80)	8 (5/3)	Living in own private home (n = 8) Married (n = 5) Widow (n = 3)	Semi-structured individual interview	Vaismora di´s (2016) content analysis	Challenges in the process were sometimes limited patient involvement, which led to ascribed goals formulated by the health worker. Patients' active participation in the conversations mainly varied with tactics or ways of professional leadership and communication skills used during conversations. When the personnel displayed active listening skills and allowed for patient participation in interactions, this led to patient-staff negotiations and clarification of rehabilitation goals. More often the staff limited

P9	2014	Butterworth JE et al./England	To investigate the association between older patients' trust in their GP and their perceptions of shared decision making	65-95+ (Unknown)	20 (11/9)	With ≥1 chronic conditions (n = 14) Married (n = 7) Divorced (n = 3) Widow (n = 6) Never married (n = 2)	Semi-structured individual interview	Thematic analysis	Some participants expressed definite trust in a GP's opinion, particularly those who had experienced continuity of care. An explanation of this opinion was usually valued, however, and perceived by participants to represent patient involvement, augmenting their trust. The provision of patient choice as a method of involvement was frequently valued and expressed greater trust in a GP who provided a definitive view in respect of their care. Participants discussed trust in the context of factors that affected their preferences for involvement. The oldest participants acknowledged increasing awareness of their own health and self-confidence in older age, wishing for information about ever more complex healthcare requirements. Characteristics that facilitated their involvement in decisions about their health care were a patient-centered, caring, attentive, and holistic approach; appearing open and honest; and treating the patient as an equal.
P10	2014	Beverly EA et al./USA	To explore older adults' values and preferences regarding type 2 diabetes care	60-83 (71,3)	25 (14/11)	Range of health conditions, including diabetes among the participants = 2-7 High education (n = 13) Married (n = 15) Retired (n = 21)	Focus group interview	Content analysis	Some participants said that their physician had never explicitly asked them about their values and preferences for diabetes care and, as a result, had not seriously considered their values and preferences for care. Overall, participants valued a strong working relationship with their diabetes physicians. Further, older adults valued physicians who encouraged them to be involved in their own care and listened to their concerns. Interestingly, several participants discussed end-of-life decision-making preferences in three of the five focus groups. For them, diabetes care preferences that would allow them to maintain the quality of life they valued extended beyond immediate treatment decisions. These individuals said that It was their choice whether to continue with their treatments and it was their choice whether to be resuscitated

P11	2014	Bynum JPW et al./USA	To understand the level of participation of very old adults, understand the process by which participants experience medical decision making, and identify barriers to greater participation in their health care decision making, in particular those that may be modifiable	80-93 (84)	29 (17/12)	Black (n = 6) Non-Hispanic white (n = 23) Widow (n = 17) Married (n = 10) Divorced (n = 1) Single (n = 1) Middle education (n = 14) High education (n = 15)	Semi-structured individual interview	Constant comparative method	The differences in decision processes across the types of care, from surgery to routine testing, highlight the importance of whether the participants felt there were any options for them to consider or even any decision to be made. There were many instances in which the participant did not perceive a choice or even that a decision was being made. Many participants described low overall participation. Some explicitly stated that they did not participate. Several barriers in communication between the patient and physician could interfere with patients engaging in the decision process. Communication barriers precluded the possibility of information sharing and dissuaded participants from asking questions
P12	2012	Sheridan NF et al./New Zealand	To explore what poor older adults, who mostly belong to ethnic minority groups with high needs, say they want from clinicians and uncovered patient powerlessness and low engagement in primary care consultations	55-75+ (Unknown)	42 (21/21)	From minority ethnic groups (n = 32) Living with family (n = 33) Living alone (n = 6) In residential care (n = 3)	In-depth interview	Street´s (2009) communication model	Few differentiated between seeing a nurse or doctor, and only one participant said a GP had made a home visit. Most participants described their relationship as 'very good', 'fine', or 'clinical', but their stories of interactions with either GPs or practice nurses revealed dissatisfaction. Being objectified and feelings of invisibility were expressed, as the practice nurses' lack of involvement. Repeatedly participants reported being upset at how they were spoken to and feeling unheard or disregarded. Cultural gestures were also seen to play an important part in revealing the subtext

[1]Only those characteristics with the most relevant information for this meta-synthesis were extracted from each study.

[2]The terminology used by the authors in the denomination of the analytical process to be followed has been respected.

Supplementary Table 4. Intra-studies characteristics.

Supplementary Table 5. Characteristics across selected studies.

Item	No. of studies addressing each item (n = 12)
Design	
Phenomenology	2
Hermeneutics	1
Grounded theory	1
Naturalistic inquiry	1
Not specified	7
Older patients´ health condition[2]	
Diabetes	5
Hearing problems	2
Vision problems	2
Physical limitation	2
Stroke	2
Parkinson´s disease	2
Cancer	3
Rheumatic disease	1
Arthritis	3
Gout	1
Hypertension	3
Cardiovascular disease	4
Heart disease	3
Kidney disease	2
COPD	3
Asthma	2
Osteoporosis	1
Depression	2
Epilepsy	1
Paraplegic	1
Neurological diseases	2
Musculoskeletal diseases	1
Multiple sclerosis	2
Not specified	4
Sampling strategy	
Purposive	9
Consecutive	1
Convenience	1
Not specified	1
Informants other than older patients	
Yes	3
No	9
Setting of data collection[1]	
Community site	2
Senior center	1
Home	7
University room	1
General practices	2
By phone	1
Field notes taken in addition to interviews	
Yes	9
Not specified	3
Audio/visual recording	
Audio recorded and transcribed verbatim	12
Data coders	
Two or more coders	9
One coder	2
Not specified	1
Use of software	
NVivo	4
Atlas.ti	3
Dedoose	1
MAXQDA Plus	1
Not specified	3
Argued use of trustworthiness criteria	
Yes	8
Not specified	4
Argued use of consolidated reporting framework	
COREQ	4
Not specified	8

[1,2] An article may have multiple responses for these items (not mutually exclusive).

Supplementary Table 6: Analysis of the studies included in the meta-synthesis using the instrument for qualitative studies Critical Appraisal Skills Programme (CASP).

Articles / Criterion	Brown EL et al. (2022)	Nilsen ER et al. (2021)	van Bussel E et al. (2019)	Mitchell J et al. (2019)	Doekhie KD et al. (2018)	Moe A et al. (2017)	Crotty BH et al. (2015)	Hedman M et al. (2015)	Butterworth JE et al. (2014)	Beverly EA et al. (2014)	Bynum JPW et al. (2014)	Sheridan NF et al. (2012)
1. Was there a clear statement of the aims of the research?	+	+	+	+	+	+	+	+	+	+	+	+
2. Is a qualitative methodology appropriate?	+	+	+	+	+	+	+	+	+	+	+	+
3. Was the research design appropriate to address the aims of the research?	-	+	-	-	+	+	-	+	-	-	+/-	-
4. Was the recruitment strategy appropriate to the aims of the research?	+	+/-	+	+	+	+	+	+	+	+	+	+
5. Was the data collected in a way that addressed the research issue?	+/-	+/-	+	+	+	+	+	+/-	+/-	+	+	+
6. Has the relationship between researcher and participants been adequately considered?	-	+	-	-	+/-	-	-	-	+	-	+/-	-
7. Have ethical issues been taken into consideration?	+	+	+	-	+	+	+/-	+	+	+/-	-	+
8. Was the data analysis sufficiently rigorous?	+	+/-	+	+	+	+	+	+	+	+	+	+
9. Is there a clear statement of findings?	+	+	+	+	+	+	+	+	+	+	+	+
10. How valuable is the research?	+	+	+	+	+	+	+	+	+	+	+	+
Overall Score (%)	**75**	**85**	**80**	**70**	**95**	**90**	**75**	**85**	**85**	**75**	**80**	**80**

Legend:

+ = Yes = 10 points; +/- = Can´t tell = 5 points; - = No = 0 point

SÍNTESIS EN ESPAÑOL DE LA PRODUCCIÓN III

La Producción I sirvió como puerta de entrada hacia el OG-TD.

La Producción II sirvió como punto de anclaje entre dos vertientes complementarias al OG-TD.

Ahora, es el turno de profundizar en la vertiente primaria del mismo.

Llegados a este punto, los ECD llegaron en todo su esplendor mediante un ACD concienzudo sobre testimonios tanto de personas mayores que vivían solas en la comunidad, como de personal de enfermería de atención primaria.

En esta ocasión, el constructo sociocultural de género se incorporó al ACD como una categoría analítica más a tener en cuenta, ya que fue un concepto que invitaba a formar parte de este estudio tras la aproximación al corpus de las transcripciones de entrevistas realizadas.

La aproximación al ACD[11] en mis ECD primarios (Producción III y IV) aparece detallada en la **Figura 8**.

Además de analizar las relaciones de poder establecidas entre pacientes mujeres mayores y personal de enfermería de atención primaria en situaciones de TDC, EP/EAP y PAC, pretendí ubicar las diferencias percibidas en los discursos de ambas actrices que subrayaran un desequilibrio de poder en dichas

[11] Como particularidad, el ACD se comenzó a realizar en español a las transcripciones de las entrevistas correspondientes a las pacientes mujeres mayores. Sin embargo, la más que considerable extensión del ACD en español del corpus analítico entraba en conflicto directo con el límite establecido en el número de palabras por la inmensa mayoría de revistas JCR internacionales relativas al área de enfermería. Debido a esta importantísima razón, opté por realizar directamente el ACD en inglés, teniendo en consideración las exigencias de dichas revistas. El ACD fue, pues, muy focalizado y conciso en la medida en que las producciones de tesis fueron orientadas a ser enviadas para publicación a revistas que publican en inglés. La única muestra de ACD en español puede apreciarse en el Anexo I de esta Tesis Doctoral.

relaciones. Por otro lado, y en consonancia con el cuadrado ideológico de van Dijk (Dijk, 2015)[12], me propuse determinar las representaciones de grupos sociales proyectadas a través de estrategias discursivas.

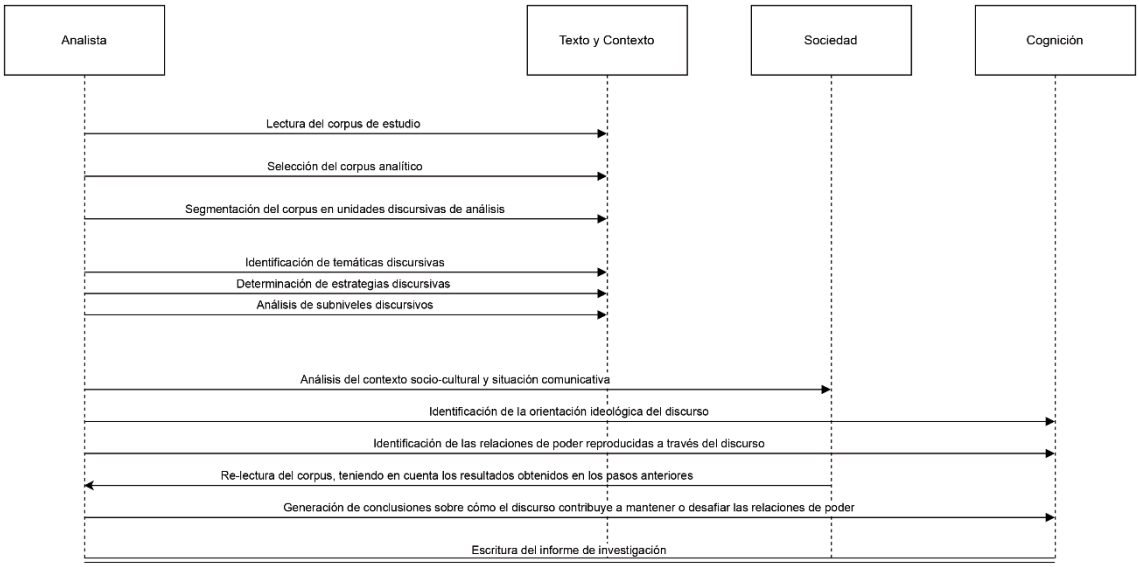

Figura 8. Aproximación al ACD en mis ECD. Elaboración propia.

Los resultados de la Producción III desvelaron en el discurso de las pacientes mujeres mayores una autoconciencia de subordinación frente a la figura de la enfermera de atención primaria y su contexto de sobrecarga de trabajo. Este concepto de subordinación perjudicó la comunicación con las profesionales. Las pacientes mujeres mayores no transmitían estados de ánimo o preferencias por falta de confianza o porque se consideraban un estorbo, incluso una carga para la actuación de las enfermeras de atención primaria.

[12] Dijk, V. (2015). *Critical Discourse Studies: A Sociocognitive Approach (new version), Methods of critical discourse analysis*. London: Sage.

Declararon que no sentían formar parte de ningún proceso de TDC sobre la gestión de sus cuidados y consideraron a la PAC como una posible fuente de problemas en su relación con las enfermeras de atención primaria. Las estrategias discursivas utilizadas por las pacientes mujeres mayores para construir su representación social fueron las de victimización, intensificadoras de inseguridad y compasión estilística.

Por otro lado, el discurso de las enfermeras de atención primaria presentó claros tintes ideológicos que empañaron la calidad de su atención: la discriminación por edad estuvo presente en sus esquemas mentales sociocognitivos respecto a sus definiciones de paciente mujer mayor; sus actitudes paternalistas, en el seno de su cognición sobre un rol de género que cumplían, les hacía actuar de manera aparentemente sobreprotectora y abnegada, de acuerdo con sus actos de habla. Las enfermeras de atención primaria adoptaron un rol de poder a través de una identidad de grupo moralmente autoritaria, que las situaba simbólicamente por encima de las pacientes mujeres mayores.

El contexto en el que se encontraban las enfermeras de atención primaria influyó negativamente en el desempeño de su trabajo, generando frustración y sensación de no ser escuchadas, algo que consideraron un ojo por ojo respecto a la EAP de las mujeres mayores. Las estrategias discursivas utilizadas por este grupo para crear su representación social fueron muy variadas, siendo estas las de generalización, ejemplificación, victimización e intensificadoras de gravedad, mostrando una amplia gama que denotaba que eran un grupo con fácil acceso a estructuras discursivas (**Figura 9**).

La primera aproximación pura al ACD dio paso a otra cuestión: ¿cómo serán las relaciones de poder entre personas mayores que vivan solas en la comunidad

y personal de enfermería de atención primaria, con respecto a TDC, EP/EAP y PAC, en un contexto cultural diferente?

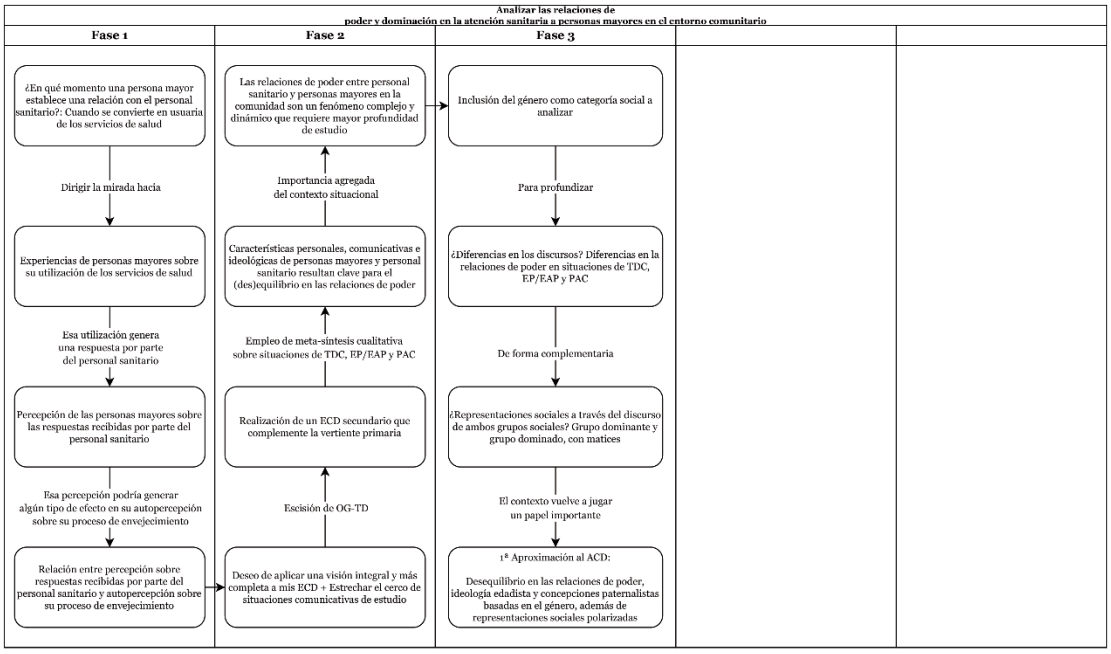

Figura 9. Hoja de ruta de la Tesis Doctoral hasta la Fase 3. Elaboración propia.

III. Active listening, shared decision-making and participation in care among older women and primary care nurses: a critical discourse analysis approach from a gender perspective.

Title

Active listening, shared decision-making and participation in care among older women and primary care nurses: a critical discourse analysis approach from a gender perspective.

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Estado de la Producción III con respecto a su publicación en una revista indexada en JCR (Journal Citation Reports)

Proceso de revisión por pares.

ABSTRACT

Background: Nursing care for older women represent a challenge worldwide due to its characteristics. When communication is impaired between primary care nurses and older women living alone, an imbalance in power relations occurs. The main objective of this study is to analyse the power relations between older women and primary care nurses in situations of active listening, shared decision-making and participation in care.

Methods: We developed a qualitative study using a discursive and gender approach in southern Spain. We used purposeful sampling to interview older women who lived alone and received home nursing care. Simultaneously, we conducted focus groups with primary care nurses who provided home care to older women. A linguistic analysis of the transcripts was carried out.

Results: Nine semi-structured face-to-face interviews were conducted with older women who lived alone and two face-to-face focus groups with four primary care nurses in each. The discourse of the participants demonstrated an imbalance in power relations. Influenced by work overload, active listening was considered a privilege in primary care nurses´ discourse. Regarding shared decision-making, older women´s discourses revealed “mirages” of real situations where they thought they were deciding. Participation in care was difficult since older women saw themselves as a nuisance in nurses´ presence, and primary care nurses did not facilitate older women to engage. Older women weren´t considered when organising home visits and had interiorised a subordinated feeling. Similarly, a strict sense of identity made primary care nurses feel powerful in their relationships with older women.

Conclusions: The discourse of older women represented them as victims of a hostile panorama whilst they were sometimes satisfied with the deficient care received. The discourse of primary care nurses used more discursive strategies to represent themselves as professionals committed to caring. However, it also revealed deficiencies in care, discriminatory components, and feelings of being limited by their working conditions. Active listening to older women and engagement in decision-making readjust empower the older women. Attending to the needs and concerns of primary care nurses could readjust the power imbalance between them and healthcare organisations.

Keywords: Critical Discourse Analysis; Gender; Older women; Primary Care Nurses; Active Listening; Shared Decision-Making; Active Participation; Power Relations.

List of abbreviations: Critical discourse analysis (CDA); Social Practice Theory (SPT); Self Perception of Ageing (SPA).

INTRODUCTION

Nursing care in the older population presents a particularly complex challenge due, among other factors, to multiple pathologies, high morbidity, and frailty that characterise this profile of patients [1]. This complexity is not always reflected in the moments of care nor how the nurse-older-patient relationship is established, creating an image of power imbalance in nursing care. The imbalance is also accentuated by issues related to sex and gender [2,3]. Several studies have shown that older women have a longer life expectancy, reaching an advanced age with more significant functional impairment [4,5]. On the other hand, traditional gender regulations —to which women continue to be linked in an industrialised society— are replicated in the current social framework and the health systems, favouring health inequities and limiting access to proper care [6]. For this reason, the nursing staff and research within the nursing discipline must consider these aspects framed in care.

To achieve this purpose, the power relations between nursing professionals and older women in the community setting should be addressed, focusing on detecting possible power imbalance and inequality among them. Within sociocritical studies, the feminist perspective provides models to elucidate the dimensions of power and the influence that history, culture, and society exert on this interaction [7]. It is therefore pertinent to explore the perspective of women involved in community nursing care processes from the angle of empowerment and equity in health, breaking down stereotypes such as ageism and social prejudices, to progressively engage older women in decision-making moments of their care process [8].

From a discursive approach, nursing care is based on establishing an efficient, communicative relationship with patients and their environment. This relationship should be bidirectional and promote, above all, quality care [9]. However, this relationship does not always correspond to reality, and therapeutic communication can be altered. Proper care will only be possible by listening and, thus, knowing older women's needs, preferences and personal values concerning the health-disease process framed in their sociocultural context [10]. To achieve this, it is essential to identify power imbalance in listening to preferences, making decisions and participating in care, and contribute to creating an equal world in which the dignity and rights of older people are respected, a group prone to being vulnerable, especially in the case of women [11,12].

In pursuit of this, previous studies have addressed the nurse-patient relationship in the older population. Mize et al. [13] focused their research on older women regarding interaction and nurse relationships. On the other hand, Nilson et al. [14] studied how a patient-centred approach influenced improving healthcare for older patients. This perspective empathised with a holistic and systematic approach to nursing care, not limited to a specific moment, being longitudinal concerning effective and fluid communication between the nurse-patient and nurse-institution pairings.

Since the interaction between older people and nurses is crucial [15], the principal aim of this study was to critically analyse the power relations between older women and primary care nurses. Subsequently, the specific objectives were to describe the situations of active listening to preferences, shared decision-making, and patient participation from older women and primary care nurses´ discourse; to identify differences in the perception of those situations between older women and primary care nurses´ discourse; to explore the discursive

strategies that shape the social representations projected by older women and primary care nurses´ discourse.

METHODS

Study design

We performed a qualitative study framed in a critical discourse analysis (CDA) approach with a gender perspective. CDA is not considered a single methodology but a set of methodological frameworks centred around an analysis linking society and discourse's linguistic component [16,17]. This study uses Van Dijk's Power Relations Theory as a reference considering his sociocognitive approach [18,19] and Foucauldian elements such as oppression and society [20]. This model focuses on the discursive sources of power, dominance, inequality and bias, connecting with Bourdieu's Social Practice Theory (SPT) [21,22]. SPT frames the relationship between gender and symbolic power in a social web where health behaviours in social groups can change due to inequality. Thus, discourse, in addition to power, reproduces gender as a social identity construct [23]. The CDA, combined with a gender perspective, attends to the social representations of gender —identities— and the role of gender in power relations within specific contexts [24,25].

To report our qualitative study, in Additional file 1, we present the completed SRQR checklist with the page and paragraph numbers stated for each item [26].

In addition, to offer a detailed and complete report of the interviews and focus groups, Additional file 2 contains the completed COREQ checklist for original qualitative studies [27].

Likewise, for an adequate presentation of information on sex and gender throughout the present study, the considerations reflected in the SAGER guidelines have been followed [28].

Setting and sample

The study was conducted in the Córdoba-Guadalquivir Health Area community care setting, specifically in two centres. The province of Córdoba is located in the north centre of the Autonomous Community of Andalusia (Southern Spain). According to data corresponding to the year 2021 extracted from the Institute of Statistics and Cartography of Andalusia, the province's total population is 322,071 (167,454 women and 154,617 men), whose rate of the population over 65 years is 19.6%. Within this community care setting are thirteen primary care centres and nine clinics in rural areas. One of the two health centres was responsible for the primary health care services of the sixth poorest suburban district in the country, according to the Urban Indicators in its 2022 edition of the National Institute of Statistics of Spain [29].

We performed purposeful sampling according to the selection criteria [30]. These criteria are included in Table 1.

Table 1. Selection criteria for older women and primary care nurses.

	Older women	Primary care nurses
Inclusion criteria	**A.** 75 years old or older. **B.** Living alone at home. **C.** Receiving nursing home care services at the time of the study.	**F.** Having at least two months of work experience in primary care settings. **G.** Having at least two months of uninterrupted work experience as a primary care nurse in the health centres of the study. **H.** Having nursing home visits to older women as part of the primary care nursing tasks.
Exclusion criteria	**D.** Scoring a suspicion of cognitive impairment in the Spanish version of the Pfeiffer test. **E.** Suffering from a terminal illness.	**I.** Not having made at least one nursing home visit per month to older women in the last two months since the study.

2

Regarding recruiting older women, the leading researcher transferred the selection criteria for this group to the nurse case managers in the health centres. The nurse case managers contacted potential participants through nurses who worked in each health centre. A three-way meeting was held between all interested older women individually, a primary care nurse, and the leading researcher. After explaining all the study information, the leading researcher arranged a second meeting with each older woman to conduct the interview.

Regarding recruiting primary care nurses, the corresponding selection criteria were transferred to the nurse care managers. These criteria were sent to nurses working in the health centres, and those interested in participating contacted the leading researcher.

Data collection

In the case of older women, we conducted nine face-to-face semi-structured interviews, which were determined by the discourse saturation criterion agreed upon between the research group in a discussion meeting [31]. In the case of primary care nurses, we performed two focus groups of four nurses each. On the one hand, we decided to conduct semi-structured interviews with older women because this tool facilitates some critical points to pivot the data collection and not limit the depth of the life experience of older women [32,33]; on the other hand, we used the focus group in the case of the primary care nurses for the following reasons: (1) achieving greater dynamism in the sessions, (2) finding a sense of the experience lived as a socio-professional group, as well as intra-group norms, codes and ideologies, (3) allowing the discourse to act as a vehicle for revealing discursive strategies in the natural communicative habitat between member group [18,19], (4) triangulating qualitative methods [32].

According to the wishes of the older women, the interview spot was their own home; an indoor and conditioned enclosure in their respective health centres, concerning primary care nurses. All the interviews and focus groups were audio-recorded and accompanied by a reflexive diary that comprised self-hermeneutical considerations, kinesics and proxemics [34]. Interviews were anonymised by randomly giving each participant a number, and the leading researcher reviewed the transcripts to ensure accuracy. Semi-structured interviews were approximately 60 minutes on average, and focus groups were 50 and 70 min. The formal caregivers of patients 4, 6 and 7 were also present during the interviews. Likewise, two observers from the research team were present separately and took field notes in each focus group. The leading researcher was the interviewer in the case of the older women and the group moderator in the case of the primary care nurses.

Regarding data collection instruments, we developed a preliminary script, the piloting of which was tested with two older women who met the same selection criteria. These primitive interviews were not incorporated into the final corpus of the study because we did this to calibrate its content a posteriori and assess whether we focused correctly on the interview encounter. Once approved the definitive guide, interviews were conducted with the older women selected based on the aforementioned criteria. Regarding primary care nurses, we carried out the focus groups after the interviews with the older women, adapting the script to have the same skeleton of content and to address the groups. Nevertheless, the guide was used as a reference as the dynamic nature of focus groups determined the course of the sessions [see Additional files 3a & 3b].

Data analysis

We employed a linguistic analysis defined by CDA that addressed the communicative event regarding the study phenomena [35,36]. Through the linguistic analysis, we aimed to explore the discursive strategies that unravel the positive representation of the self (semantic macro-strategy of in-group favouritism) and the negative representation of the other (semantic macro-strategy of derogation of the out-group). We identified these discursive strategies representations by analysing speech acts that illustrate authority figures, comparisons, exemplifications, generalisations, polarisations, presuppositions, and victimisations [37,38].

For the determination of the research corpus, we followed the steps recommended by Bolívar [39]: (a) to differentiate the textual corpus from the research corpus, (b) to select informative material through an awareness of critical assumptions and problems to be addressed, (c) to determine the linguistic sublevels to approach.

After obtaining the research corpus, we chose to approach the analysis of the pragmatic, syntactic, semantic, rhetorical-stylistic and cognitive sublevels, as well as a description of the discursive strategies deployed by the participants.

Trustworthiness and rigour

We assessed the trustworthiness and rigour of our study through the rigour and quality criteria suggested by Lincoln and Guba [31]. In addition to a detailed explanation by the team, we also identified the rigour techniques we used to address each criterion [40,41]. This information can be seen in the Additional file 4.

Ethical considerations

This study received approval from the Research Ethics Committee of Córdoba. We informed all the participants about the research before the data collection through an information sheet, and informed consent to participate was collected by signing. We explained to the participants that the data collected would be used for research purposes only and that all identifying information would be anonymised to safeguard their identity. We informed the participants about (a) the objectives of the research, (b) the guarantee of the confidential nature of personal data, (c) the custody and handling of the data, (d) the disclosure of the results of this research, (e) the possibility of leaving the study at any time and without any consequences.

RESULTS

Description of the participants

All participating older people were Spanish white women, with a mean age of 87 (Table 2). We obtained older women´s health information about their medical and nursing records through the nurse case managers. As for the exclusion criterion D for older women, the reference cut-off point was four or more errors since all the older women participating in this study had great difficulties reading and writing [42]. On the other hand, the socioeconomic level was obtained by self-report through a direct question to each participant outside the interview script provided.

In the case of primary care nurses were all white Spanish women, with a mean age of 50 years in group X and 57 years in group Y (Table 3). The corresponding sociodemographic information was collected through a self-filled registration sheet before each focus group.

Conceptual map for the synthesis of the results

Visually, Figure 1 exemplifies how the discourses of primary care nurses and older women shape the reality of active listening, shared decision-making, and participation in care.

Narrative development of the results

The results of this study show explicit representations of power imbalance in the form of speech acts belonging to the discourses. The older women adopted a predominantly subordinate role, while the primary care nurses, despite trying to convey an image of commitment to the care they provided, adopted a dominant role. However, according to the differences in both perceptions, older women and

primary care nurses were responsible for ineffective communication, a lack of shared decision-making, and an unrealistic view of participation in care.

To facilitate the comprehension of the results, we present all of them in Table 4 in an organised as major themes, minor themes, and the extracts of speech acts that integrate them.

To facilitate further understanding of the phenomenon studied and its hierarchical distribution, we also calculated in Additional file 5 the magnitude of the derived findings provided by older women, primary care nurses and in common [43].

We synthesised the major themes until a higher level of qualitative meaning was found; the study patterns followed: Ideology in care, context as the axis of quality of care, a rift in communication and power imbalance in the nurse-patient relationship.

Pattern A: Ideology in care.

Primary care nurses entirely marked the first study pattern. The speech acts of the nurses showed the sociocognitive panorama that supports the bases of their work attitude, which held evident ideological traits that biased the care they provide.

Major theme 1: Influence of ageism on care.

The discursive strategies of generalisation, through the use of the syntax of quantity, aphorisms, and use of impersonal verbs; of severity intensification and polarisation, through the usage of qualifying adjectives, enumerations and repetitions showed the conception that the nurses had rooted in their cognitive heritage: older patients are a problematic patient profile to manage, who do not face their age as a characteristic definition of their state of health.

(2) Older people think their problem is solved with pills (no. X/10).

(3) It looks like the older patients, you already know that it doesn't matter if you talk to them that you already know that they come to you to prescribe pills and that it doesn't matter what you speak to them that when they leave the door, they will do what they want... (no. X/10).

This contrasted with the projection of a public image of involvement and consideration for old age, illustrated by suggesting that older women should prevent before falling.

(1) I have [she names an older woman], who has already fallen many times, she has a walking frame at home. I tell her to lean on it, to try... and I come another day, and she tells me she got stitches on the head because she fell. And no matter how hard you try, they don't change (no. X/10).

The primary care nurses presented clear signs of ageism in their speech acts but also introduced the concept that the older women had an ageist attitude by not accepting advanced age.

(4) She's not old, and you tell her something. She says, “that's because I'm old?”, what if I take the walking frame, am I old? And she is 90 years old, but that is your security, it is her security, so then... (no. X/10).

The primary care nurses also established a difference in approach between young and older patients, anticipating the possible needs and declaring that since young people deal with more information, any health issue should be addressed more clearly with them than older patients.

(8) Many young patients with wound care have already seen what is good and what is not. Now you have to be more... tactful, in explaining the procedure (no. Y/17).

Major theme 3: Influence of gender on care.

Firstly, the conception of gender had an essential impact on the ideology of care when primary care nurses, in the first place, presupposed that the responsibility for a male older diabetic patient´s health lay partly with his wife because she was responsible for taking care of his meals.

(16) When a diabetic man comes here, I usually tell him, tell him to come with his wife too, because she is also the one who... (no. X/10).

(17) [Referencing (16)] Who is the one who cooks the meal for him (no. X/13).

Secondly, the nurses also declared that they developed paternalistic behaviours and excessive protection of their older patients. Their discursive strategy focused on adopting a public image of a victim —in the face of an incessant demand by older patients— using a lexicon with clear ideological implications.

(18) But maybe I have a more paternalistic attitude than my colleagues, and I would often like to get rid of it, but I don't know. I don't know why I don't know how to say no to people either. Everything they blame me, they trick me, and I say yes. So that leads to much sleep being taken away, but oh well. So there are things that I know I'm not doing well (no. Y/17).

Pattern B: Context as the axis of quality of care.

The study phenomena comprised in the objectives of this study gained strength by giving shape to the second study pattern. The findings not only

revealed deficiencies in nursing care in situations of active listening, shared decision-making and participation, but also the nursing labour context became highly relevant when misaligning the attitude and approach of primary care nurses regarding managing such situations.

Major theme 5: Active listening and work overload: a privilege.

Older women´s feeling of not being listened to was due to primary care nurses' work overload. The speech acts that indicated this gained an illocutionary force that seemed to create a public image of older women as another number in the primary care nurse's portfolio of services.

(34) She says she also has to attend to many people. She says, “It's just not you alone, but... it's another, another, another. One day I dedicate to one, another day I dedicate to another” (no. 2).

On occasions, the older women, using apparent concessions, attempted to persuade by introducing a positive component in favour of the nursing collective to create a non-negative public image. Then, they followed with a contradictory statement.

(35) Of course, I don't think she [the nurse] won't listen to me. That everyone listens, right? Although later they say, look, this is how it is, it is like that, and it's over (no. 5).

The older women maintained the cognitive assumption that they had the right to be listened to and that the nurse had the duty to listen to them.

(36) Even if she doesn’t want to, she has to listen to me, whatever I tell her, right? And she comes running, and maybe she can stop; if I talk to her about anything, the woman should listen to me (no. 5).

These assumptions collided with the speech acts of the primary care nurses, who did not fulfil older women's desires to be heard: these suggested two different implicatures. First, if fewer patients were to be attended, the primary care nurses could dedicate more time to listen to older women; second, everyone deserves to be heard, and therefore nurses also deserve to be heard, this being denied and ignored on numerous occasions. Thus, primary care nurses presented themselves as a social group that was also vulnerable, and little listened to, ousted by the inefficient organisation of care and work overload.

(37) It´s not always possible because there are many, and they want you to be with them all the time. You can't satisfy everyone (no. Y/15).

(38) Of course, they ask. People demand to listen. We all require listening. And we also like to listen to each other. (…) Patients are the same everywhere. It is the same whether they are rich, poor, or… People demand much listening. I notice that. Do we give it to them? When we can. When we can't, we don't give it to them (no. Y/17).

Major theme 6: Decision making and work overload: a form of vertical power.

The older women eclipsed the opportunity to decide when they declared not to talk to the nurses.

(39) I hardly talk to her. I don't speak. After all, she doesn't have much time because she has… It's just that people who come like this don't give you time to talk to them because you entertain them (no. 5).

There was a case of a pact of silence between the primary care nurse and the older woman, where the first opted not to carry out some intervention, such

as a blood pressure check. The older woman was grateful that this decision was made due to her fear of explicitly knowing her state of health. This did not represent shared decision-making: the nurse decided not to check the blood pressure promptly because she assumed it would be high and, in turn, generated concern in the older patient. In this sense, older women displayed examples like this to extol the commitment of primary care nurses to be sensitive to their preferences and mask an evasion of shared decision-making, which was reinforced through repeated syntax parallelisms with great illocutionary force.

(40) I let her do what she says. “Oops, well, today I'm not going to take your blood pressure”. She doesn't like to do that very much because she knows I have it high and I... Well, it worries me... and it raises a lot. And she has a hard time lowering it. What she does many times is not take it so as not to upset me, so as not to worry me, but she has suffered it (no. 6).

This is why the older women perceived primary care nurses as empathic and compassionate throughout the discourse. Still, at the same time, there was a lack of equality since the imbalance in decision-making was total.

On the other hand, this was easily seen when we turned our gaze to primary care nurses´ discourse, who used a lexicon with a pragmatic charge of domination and the use of verbal structures with an oppressive connotation.

(41) So you have to get used to them a bit, and often it is true that the barrier, when you impose, but look, well, “This would come in handy”, for example (no. X/13).

(42) And now you tell her, well, first of all, don't scold her, how will you scold her? And then they don't even open their houses to you again. That is the art, too, of... for you to keep opening up and see if any habit changes (no. X/13).

Furthermore, the discourse of the primary care nurses resounded in that the ability to decide did not correspond to older women but rather to their illness circumstances and health conditions.

(43) I believe that the changes come from that. Well, they fall, and they are the ones who find themselves with a broken hip, and the world already decides for them. They stop deciding (no. X/10).

Major theme 7: Participation, work overload and personal characteristics.

The illocutionary speech acts of older women sought to convey a public image of agency and collaboration. For this purpose, they used the discursive resource of negation with an inverse effect. By making explicit what they did not want to do, they achieved precisely the opposite, so the intention to underline that they were not very problematic achieved that goal.

(44) I am, of course, a woman, not because I want to sell myself a little problematic, you know? I adapt to... [the situation] (no. 3).

Older women discarded the possibility of participating in their care by embracing nurses' workload because they did not have the opportunity to do so. The speech acts of the older women were hasty, disconnected and unfinished, so the primary care nurses' discourse influenced older women´s cognitive model of

active participation in care. The older women assumed that the only way to participate was through a circumstance beyond their control, the workload of the primary care nurse who cared for them.

(45) No, because this woman [the nurse] is very busy, and you can't say... What am I going to say? If this woman... "We have a mess; such a mess...". Of course, they all come running (no. 5).

In other words, older women considered themselves subdued to a context that did not allow them to participate.

The power relationship this time transcended the figure of the primary care nurse to reach the health system organisation. The primary care nurses' statements once again clashed with those of the older women, saying they were assertive and facilitated the participation of older women.

(47) We inform... They are told (...) You can try to negotiate, but they don't change much either... their behaviours and minds (no. X/11).

The nurses based their inclusive actions on informing older women and understanding how to make them participate by making them aware of their health and, therefore, of their limitations.

(49) You make her participate: at least make her aware of her limitations, of what would be suitable for her (no. X/13).

The primary care nurses exercised discursive strategies of generalisation and exemplification, positioning themselves as professionals capable of involving older women in the care processes. However, there were difficulties when older patients did not wish to be engaged.

(52) Also, it's still an agreement between them [the older women] and us; you can't tell them everything they have to do if they don't like it because if they don't, they won't make any changes. So, you have to come to an agreement (no. X/10).

(53) There are other things, we check vital signs, the medicine chest, “Let's see what it has”, and, come on, I don't know about your [referring the other nurses] case, but in many cases, they show you what they want you to know, and not what they really have (no. Y/14).

Major theme 10: Time for giving proper attention and work overload: a frustrated wish.

There was an imbalance between older women´s needs and compliance: here, a desire to receive more care predominated, but once again, due to the primary care nurses´ work overload, that desire was frustrated. This implicature was supported using illocutionary exclamatory statements and conversational resources that relativised seriousness, such as laughter, and the rephrasing of arguments already used by the nurses to intensify their views.

(59) Of course, I would like that! But since she comes with... [she laughs] With that bit of time, she has to go from here to there... (no. 3).

Older women did not explain why they would like the primary care nurses to spend more time with them: they argued why they presuppose that the nurses did not spend that time instead. This implied that having little time was something nurses did not want, so the locus of power fell neither on the older women nor the nurses but on those who “screw over”.

(60) No... I know they [the nurses] have much work. You know they've been screwed over enough by others. (no. 4).

(61) No, not me, because the woman comes running! I open that door [she points out the entrance door] for her so she doesn´t lose time. She has to visit another, and then she has to go there... she says, “We have blood to collect today”. And as she comes, “Oh, oh! Today I come quickly, what a load I have today” (no. 5).

The power relationship here was once again translated into healthcare organisational elements framed in the following ranks: firstly, those who “screw over” or, in other words, the people in charge, which prevented primary care nurses from the opportunity to spend more time with older women; secondly, the nurses themselves who, through their speech acts, annulled the possibility of reversing this situation; thirdly, older women, who saw their desire to receive more care time double denied by both the first and the second ranks.

The speech acts of the older women revealed a differentiation in the care they received: one thing was receiving a visit from the primary care nurse, and another was the time spent during that visit. Regarding the second, older women did not clarify whether the nurse spent much or little time caring for them in the first instance. Still, throughout the discourse of an older woman, there was the presupposition of illocutionary force accompanied by a metaphor that the nurses spent insufficient time.

(64) Well, I understand that little angel has worked a lot... Much work. And if she must attend to several patients... “The blood, the anticoagulants, the wound care...” and so on... I don't think she has a good time for you to stop her either... (no. 9).

However, there was another illocutionary effort by the older women to exonerate primary care nurses from their inefficient praxis at the same time; that is, they tried to make public the assumption that the professionals who cared for them were not only interested in caring for them but also met older women´s necessities. These presuppositions acquired great perlocutionary force since the older women sometimes identified an almost admiration feeling for the commitment they perceived from the primary care nurses.

(62) She has never told me, "I can't go". No, she's coming. More time, less time. "Oh, I have to go because I'm in a hurry. I'm in a lot of..." She's always very loaded. And she consults from here to the doctor (no. 6).

(63) She is very loaded. She is very interested [in the sense that the nurse seems interested in the older woman's well-being], and it doesn't bother me; on the contrary, I see her... (no. 6).

With all this, it was just a confirmation that the nurses —in the eyes of the older patients— were very busy, but even so, they showed interest in caring for them.

Pattern C: A rift in communication.

The third study pattern represented a communicative interference in which complications constituted by personal characteristics from the older adults and the primary care nurses and the lack of disposition and communicative attitude cracked a fissure between the relationship both actresses maintained during nursing care. These non-therapeutic situations could be saved numerous

times if a more beneficial healthcare context supported a more balanced and horizontal approach between equals.

Major theme 2: Absence in the organisation of care.

Older women sometimes found it difficult to argue in favour of nurses' good work in managing visits and time slots. Discursive strategies that intensify insecurity, such as silences, hesitant language, and zigzagging speech acts, hinted discomfort with the questions raised.

(12) No, sometimes she comes because she had to; she always had a fixed day, the last two days of the month she always came. And she no longer called; she showed up... Oh, [she names the nurse], how are you coming and not... "Don´t you know already that I come these days?" (no. 6).

There were times when older women found themselves at a crossroads that they presupposed did not correspond to them when they considered whether to attend leisure needs or instead attend a sudden visit that had not previously agreed with the primary care nurses. These situations were visibly uncomfortable in the speech acts of an older woman using syntax constructions that served as conflict intensifiers.

(9) Well... they call me. And I have an appointment with the hairdresser. What do I tell the hairdresser now? That I'm not going? And what do I say to the nurse? Do not come? [she laughs] Yeah, I question, I call into question (no. 1).

However, after raising these dilemmas with insecurity, a resounding reversal in her speech acts —more concise and direct— gave way to an apparent decision. The older woman decided on that occasion to dispense with the unscheduled visit by the primary care nurses.

(10) [Interviewer asks referencing (9): and what do you do?] Well, go to the hairdresser's, because I feel fine and don't need the nurse right now... And I need the hairdresser's because I'm going out. And I decide to go to the hairdresser (no. 1).

It was notorious how the older woman defended this with assertive, clear and confident speech acts of illocutionary force and acquiring an image of a role of power and choice. However, this could be considered a mirage of a decision-making situation since she believed she was deciding but was forced to resolve something previously imposed by a previous decision of the nurses —not reconciling with any other activity previously scheduled by the older woman. Therefore, the primary care nurses held a substantial role of power in that situation.

The discursive strategies used by older women also acquired a metaphorical component with considerable pragmatic and illocutionary force.

(11) No, the nurses come directly, and if I'm not there, well, the little angels leave. I can't demand an hour from them because they have much work (no. 4).

This resource fulfilled two functions: first, to show a compassionate attitude free of locus of power, thus renouncing the possibility of coordinating with the primary care nurses; the second, to create a public image of tenderness and a docile patient who feels distressed when the nurses —even without having previously consulted with older women about visiting hours— went to their homes and were not present. The responsibility, therefore, fell on the older women for not being at home and not on the nurses.

Although older women made their preferences explicit, sometimes they did not communicate them to the primary care nurses.

(13) [Referencing (12): and do you tell the nurses what you prefer…?] Well, I´d prefer that she reports me because since I'm alone, sometimes I'm in a housecoat, sometimes I'm… [she laughs]. (no. 6).

Hence, their role as passive patients emerged at that moment: they felt uncomfortable when they were not notified —actually, the older women preferred to be informed— but did not express that discomfort.

Major theme 4: Ineffective communication: opposing attitudes.

Regarding the deficit of trust with the nurses, the speech act where an older woman tried to show power to decide when she introduced a relative as a communicative alternative was striking. Not sharing thoughts with the nurses represented the older woman´s verbal regret for not doing so.

(19) If I feel bad, I count on my sister. That´s it. I have more confidence in her (no. 1).

(20) I say many times, I think for myself. (…) I think so. I think about it to myself, but not to… tell anyone (…) But, yes, I had to say to the nurse (no. 1).

The older women tried expressions that sought to relieve the seriousness of a non-therapeutic communicative situation, such as using rhetorical question resources accompanied by laughter, thus establishing a tone of certain lightness and minor importance.

(22) It seems… I don't care. But since I have no problems… What do I say? [she laughs] (no. 2).

On the other hand, there was a case in which the stylistic expression gained remarkable strength since it had such an illocutionary charge, displacing the

locus of action to an inanimate subject with the use of a verbal form lacking agency.

(23) I tell her [the nurse] often that the afternoons seem very long for me (no. 2).

This made us see that there are times when older women felt lonely and lacked the power to reverse those situations of loneliness, despite communicating this time to the primary care nurses. This expression had a metaphorical, abstract background, giving a natural phenomenon such as the passage of time the ability to shape the real world of older women, having an intention prone to creating compassion and empathy.

Throughout the various speech acts of the older women, there was also an illocutionary force that made us detect a state that crossed the line between not communicating for lack of necessity and not communicating because they considered themselves a burden, representing themselves as a nuisance for the performance of home nursing tasks.

(24) It makes me very tired of that. It is because I say the nurses have their work, they have their check-ups, their things and I am not going to spoil them (no. 3).

(25) I don't want to bother my children either. And when something hurts me half the time, I don't even tell them. (...) Because I don't want them to suffer! I'm suffering a lot... (no. 3).

Regarding the discourse of the primary care nurses, they felt pointed out by the older patients and in a blind alley since they stated that on certain occasions, they were unsure how to act due to possible adverse reactions from the

older patients and relatives. In those speech acts, they used rhetorical-stylistic resources such as rhetorical questions and conversational resources such as laughter to lower the tone and reach complicity.

(29) Many say, “their nurse had to tell the patient to wash”. And you say... “let's see. Do I tell him...? How do I tell him?” Well... Sometimes... and if you tell him, he gets offended. And the wife asks for another nurse because she says I made her see that she did not take good care of her husband (no. X/11).

(30) You go to their house, and that´s tough already. “Where does that carpet come from?” They tell you the story of that carpet. That she brought it from... “Excuse me? You´re going to take it away? Why? This furniture... what? My husband and I put it up, this piece of furniture here isn´t going anywhere...”. But look, the walking frame does not fit. Well, I'm left without a walking frame! But I don't remove that piece of furniture or the carpet [she laughs] (no. X/11).

The nurses' discourse in these terms tried by all means to illustrate, through implicatures, the frustration they sometimes felt when they wanted to seek an improvement in the health status of older women and, at the same time, could not avoid slipping the preconception that everything happens according to what older people want at the moment, giving older people some power. However, this contrasted strongly with the discourse of older women, who attributed the ability to act outside of themselves.

Pattern D: Power imbalance in the nurse-patient relationship.

In the last study pattern, we were glaringly able to detect the power imbalance between older women and primary care nurses. From a sociocognitive point of view, the speech acts of both actresses denoted a discriminatory conception of care embedded in their mental processes, where the patient was

someone who receives and does not demand; the care provider was someone who knows and therefore, an indisputable authority in her field of action.

Major theme 8: Normalised subordination of the older patient.

The older women conveyed the assumption that asking the primary care nurses to perform some extra activity was an abuse of power. Older women, in these cases, saw themselves in a position of power for the mere fact of receiving nursing services. Instead of becoming a legitimate resource they could use as needed, this became a self-limiting resource: older women assumed that nurses should not adapt to their individual needs, relegating their health states one step lower to avoid interfering with the activities the nurses carried out systematically.

(54) I don't abuse anyone or anything (no. 2).

(55) I have nothing to do. I don't have to force her to do anything (no. 2).

This made more sense when they attributed not asking for help to the primary care nurses' work overload.

(56) No, because I tell you this, I understand that they have much work and there are very few people. Her work, you realise, that she not only works there, in the office, but then she has a home visit, another visit, another old one, another older one... (no. 4).

However, this seemed to be a discursive strategy directly influenced by a circumstance acquired by two different possibilities: first, it was evident that the older patient could not know the real labour context of a particular nurse unless that nurse had told her previously; the second, it was their presupposition, that is, they considered that nurses did not have time to attend to their extra needs.

Major theme 9: Moral authority of the nurse (57), (58).

Finally, we identified in the discourse of the primary care nurses that age —when they referred to themselves— was an indicator of wisdom and moral authority, something that suddenly contrasted when they talked about advanced age in the case of the older women, according to the ageist attitude displayed in study pattern A.

(57) Here we are, the oldest, and we´ve worked for many years. We have had an outstanding school. (…) I will not tell you that it is one of the best because it sounds pedantic, but it has given us a reasonably good job. (…) We are trying to convey this to the young nurses who have come recently (no. Y/17).

In addition to the veiled intentionality in the primary care nurses' speech acts, the lexicon used denoted pride when referencing their training as the best possible, which they tried to convey to younger nurses.

Furthermore, they closed ranks around the nursing team, placing the medical figure on the balance of multidisciplinary, sometimes prone to question the authority and power of nurses.

(58) It also counts not only the nurse but the team. If you're a good nurse, but then the doctor you're dealing with is a little b******, huh? Who goes to... to the nurse, meh [she makes a derogatory gesture], that throws you down a lot. (no. Y/16).

Therefore, the speech acts of the nurses showed us a sharp sense of the social group as an essential component in their professional identity and an emblem of their category of power towards older women, sometimes questioned by other teammates. Thus, not only an imbalance of power between social groups

was detected, female older patients and primary care nurses, but also possible intra-social group disagreements between nurses and doctors.

DISCUSSION

The results of this study revealed that, above all, age discrimination remains silent in society, especially in health care [44]. The primary care nurses in our study diverted the ineffective results of their health interventions towards an attitude of the older women with ageist overtones and a lack of commitment. This agrees with Tajfel's Social Identity Theory [45], which considers the attitude of different social groups as a reflection of the identity of belonging to a group, which tries to make their excellent work visible above others, over which they stand out other negative aspects [18,37]. The discourse of the older women also revealed that they had self-ageist conceptions, which is consistent with Levy's Stereotype Embodiment Theory (SET) [46], which describes how older people internalise a negative self-perception of ageing (SPA) by incorporating ageist signals that society performs subtly. On the other hand, gender ideology was also present in the results concerning primary care nurses, who sometimes assumed paternalistic behaviours that prevented them from refusing any request from older people. Therefore, the discursive victimisation strategy used by nurses tried to take a positive public image, basing care as a labour of love and sacrifice rather than professional competence. This was consistent with what was exposed by Saillant [47], who postulates the concept of caring as a gender issue and a direct consequence of unbalanced power relations between the sexes [48]. The nursing care processes contemplated in our study's objectives greatly impacted older women's discourses, becoming the epicentre of the imbalance in power relations. This importance of reconciling active listening, decision making and participation in older people is consistent with what Koskenniemi et al. [49] maintained as the pillars that the older people themselves defined when referring to care based on

respect: acceptance, active listening, engagement and warmth in care [50]. However, in the present study, the discourse of older women diminished the appearance of active listening processes due to the unavailability of primary care nurses. These results are consistent with other studies that point to a poor attitude on the part of nurses and the importance of this in terms of the inclination to listen to older patients and take their preferences seriously [51,52]. On the other hand, from the point of view of the primary care nurses' discourse, there was a component of stress and impotence due to the lack of sufficient opportunities that would allow them to develop active listening towards all older patients, something consistent with the results of other studies [53,54]. Regarding shared decision-making situations, in the results of this study, it was readily apparent that, despite appearing sensitive moments for older women to decide, they did not materialise in real decision-making situations. This is consistent with other studies that consider this process a phenomenon full of uncertainty that requires an attitude prone to dialogue on the part of older patients and health personnel [55,56]. On the other hand, the discourse of primary care nurses presented clear signs of power imbalance in which they adopted a dominant role over older women, being consistent with other studies, which highlight the feeling of disempowerment in older people when it occurs [57], especially in the case of older women [13]. Regarding active participation in care, the primary care nurses in our study seemed to know communication tools to engage older women to participate in their care. Still, due to the personal characteristics of the older women, this task was not easy. This is consistent with other studies that describe a perception of health personnel who also classify older people as stubborn and complicated in the attempt to include them in care processes [58,59]. All these moments, related to situations of active listening,

shared decision-making and participation in care, were plagued with anomalies that did not allow older women to take an active agency role in their care, nor did primary care nurses establish therapeutic communication with them. However, one of the star elements responsible for such interference in the relationships between primary care nurses and older women was the work overload suffered by nurses. These circumstances, present at all times, are consistent with numerous studies that point to working conditions as causing, in part, the power imbalance between the two and a decline in the quality of care provided by health personnel in primary care settings [60–62]. This work overload, as reflected by Lindberg et al. [63] in their research, could explain the fact that nurses were sometimes forced to make home visits not previously agreed upon with older women, directing the power imbalance described by the older women's discourses not so much towards interpersonal issues, but to organisational issues. Regarding the imbalance imposed in the roles of power between primary care nurses and older women, paradoxically, there is a certain contrast between the results of the present study and the work carried out by Juujärvi et al. [64], who identified older patients as overly demanding when asking for favours and giving orders, as well as treating nurses as if they were servants. The older women in the present study did not request extra help and interpreted this as an abuse of power from their patient role and not a right. This could also be explained by the SET, through which they considered themselves a burden or a nuisance, sentiments also reflected in speech acts from the older women in this study [65,66].

Strengths and limitations of this study.

The main strength of this study lies in incorporating the socio-critical perspective of CDA into the context of qualitative research in health sciences,

specifically in the nursing discipline. The CDA has already proven helpful in nursing inquiry, as Powers [67] proposed. The study of speech acts and the pragmatics of communicative acts is an effort with great rewards in researching situations where communication is the axis of care [68,69]. On the other hand, we have invested a great effort in describing in detail the methodological framework of this study, in addition to adequately organising the results obtained, providing in-depth information on the data collection process and following criteria of rigour and quality.

The limitations of this study address the decision to focus our study on older women who lived alone because it is associated with vulnerability in advanced age. Recent studies linked a negative SPA with loneliness, isolation, and depressive symptoms [70,71]. This evidence has affected our results, leading to a negative SPA. Other older women in more varied social circumstances could have provided some variation concerning SPA. On the other hand, there were three interviews with older women in which their formal caregivers were also present. This fact could influence her speech somehow since the presence of third parties might modify the communicative situation. Another limitation of this study may reside in the size of the corpus analysed, being excessively large compared to the textual extracts that are usually handled in other disciplines far from nursing and analytically framed in the CDA. Due to the deep and extensive degree of detail held by microanalysis of language planes, it was unfeasible for logistical and time reasons to apply it to this study. For this reason, we decided to focus on the macroanalysis of the planes previously mentioned in the methodology section. Not for this reason, the principles of CDA agree perfectly with what was stated by Malterud et al. [72], who stipulate that in qualitative research, a sample rich in terms of information requires a low number of participants to confer it.

Relevance to clinical practice and healthcare policies.

The present study has revealed an imbalance in power relations between primary care nurses and older women. The negative effect of this imbalance on situations of active listening to preferences, shared decision-making, and participation in care reveals an urgent need to develop measures and interventions that promote a horizontal collaboration relationship between primary care nurses and older women. Implementing alternative response models to the health problems of older people in the community setting so that it is possible to include them in the decision-making processes and participation in care is vital to providing quality nursing care [73]. On the other hand, a detrimental context in which primary care nurses find themselves has been highlighted, which causes a work overload whose effects are well-known and supported by the scientific literature, negatively impacting the quality of care. For this reason, it is urgent to attend to the needs of nurses and to help the power imbalance between primary care nurses and healthcare organisations.

CONCLUSIONS

The results of this study present evident contradictions between the perception that primary care nurses and older women have about situations of active listening to preferences, shared decision-making, and participation in nursing care. The discourse of older women shows a self-awareness of subordination in the face of the primary care nurse's figure and their work overload context. This concept of subordination harms communication with professionals, which is often nonexistent. Older women hardly share moods or preferences due to a lack of confidence or because they consider themselves a nuisance or even a burden to primary care nurses´ performance. They declare that they are not part of any decision-making process regarding managing their care and consider their participation a possible source of problems regarding their relationship with the primary care nurses. The discursive strategies used by older women to build their social representation were those of victimisation, insecurity intensifiers and stylistic compassion. On the other hand, the discourse of primary care nurses presents clear ideological overtones that tarnish the quality of their care: ageism is present in their socio-cognitive mental schemes regarding their definitions of an older female patient; their paternalistic attitudes make them act in an overprotective and self-sacrificing manner, according to their speech acts. Primary care nurses adopt a role of power through a morally authoritarian group identity, which places them symbolically above older women. The context in which the primary care nurses find themselves has a negative influence on carrying out their work as they would like, generating frustration and a feeling of not being heard, something that they consider an eye for an eye regarding the active listening of older women. The discursive strategies used by

this group to create their social representation were very varied, being those of generalisation, exemplification, victimisation, and severity intensifiers, showing a wide range that denotes that they are a group with easy access to discursive structures to reproduce their social image through speech acts.

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Tables, Figures and Supplementary Material

Table 2. Characteristics of older women (n = 9).

Participant No.	Age	Medical diagnosis	NANDA nursing diagnosis	Pfeiffer test score Spanish version in no. of mistakes	Barthel index score out of 100 (meaning)	Norton scale score out of 20 (meaning)	Social support (type)	Economic difficulties (with help)
1	95	Bladder cancer (operated), cataracts	Activity intolerance, impaired urinary elimination, risk for falls	0	95 (slight dependency)	17 (without risk)	Yes (family)	No (no)
2	88	Hip replacement, hypertension, Ménière's disease, osteoarthritis	Anxiety, bathing self-care deficit, constipation, dressing self-care deficit, impaired home maintenance, impaired physical mobility, impaired walking, risk for falls, risk for loneliness, risk for social isolation	3	85 (moderate dependency)	14 (at risk)	No	No (no)
3	78	COPD, smoking	Activity intolerance, impaired gas exchange, ineffective breathing	0	80 (moderate dependency)	14 (at risk)	Yes (friends)	No (no)

			pattern, risk for impaired skin integrity, risk for falls					
4	84	Obesity, type II Diabetes Mellitus	Activity intolerance, imbalanced nutrition, ineffective health management, sedentary lifestyle	2	85 (moderate dependency)	16 (without risk)	Yes (formal caregiver)	Yes (yes)
5	97	Duodenitis, gastritis, hypertension, mild renal failure, mitral regurgitation	Activity intolerance, imbalanced nutrition, impaired urinary elimination, ineffective health management, risk for impaired skin integrity, risk for falls	3	25 (severe dependency)	10 (at risk)	Yes (family)	No (no)
6	86	Atrial fibrillation, epicondylitis, hypercholesterolemia, hypertension	Activity intolerance, chronic pain, hearing impairment, impaired physical mobility, risk for falls	1	90 (moderate dependency)	17 (without risk)	Yes (informal caregiver)	No (no)
7	90	Colonic diverticulitis, coxarthrosis, discarthrosis, dizziness, glaucoma, gonarthrosis, hypertension,	Functional urinary incontinence, impaired physical mobility, impaired home maintenance,	3	55 (severe dependency)	12 (at risk)	Yes (formal caregiver)	No (no)

		ischemic heart disease, osteoporosis, type II Diabetes Mellitus	ineffective coping, risk for falls					
8	84	Atrial fibrillation, breast cancer, colon adenocarcinoma, knee osteoarthritis, obesity	Chronic pain, functional urinary incontinence, imbalanced nutrition, ineffective health management, risk for falls	0	90 (moderate dependency)	17 (without risk)	Yes (family)	No (no)
9	83	Osteoporosis	Functional urinary incontinence	2	80 (moderate dependency)	17 (without risk)	Yes (family)	Yes (no)

Table 3. Characteristics of primary care nurses (n = 8).

Focal group No.	Participant No.	Age in years	Qualified nursing professional in years	Nursing professional employment in years	Nursing professional employment in the current health centre in years (months)
X	10	42	21	17	2 (6)
X	11	62	42	42	13(0)
X	12	52	32	32	16(0)
X	13	43	23	22	7(0)
Y	14	58	34	34	21(0)
Y	15	63	40	40	13(0)
Y	16	56	24	24	2(0)
Y	17	52	27	27	25(0)

Table 4. Major themes, minor themes and informative excerpts of CDA from the research corpus.

<table>
<tr><th colspan="2">Major theme 1: Influence of ageism on care</th></tr>
<tr><th colspan="2">Minor theme 1: Prejudice around age</th></tr>
<tr><th colspan="2">Primary care nurses</th></tr>
<tr><td colspan="2">(1) I have [she names an older woman], who has already fallen many times, she has a walking frame at home. I tell her to lean on it, to try... and I come another day, and she tells me she got stitches on the head because she fell. And no matter how hard you try, they don't change (no. X/10).
(2) Older people think their problem is solved with pills (no. X/10).
(3) It looks like the older patients, you already know that it doesn't matter if you talk to them that you already know that they come to you to prescribe pills and that it doesn't matter what you speak to them that when they leave the door, they will do what they want... (no. X/10).
(4) She's not old, and you tell her something. She says, “that's because I'm old?”, what if I take the walking frame, am I old? And she is 90 years old, but that is your security, it is her security, so then... (no. X/10).
(5) [Referencing (4)] But they are not old, “I am not old”, no... (no. X/11).
(6) Where do you see the supposed inequality... between old and young, where do you see it? (no. X/12).
(7) It occurs in numerous older people; they have another vision. And you should have it too because that is what I have told you. For instance, they are at the expense of having food brought to them or of being unable to make meals and in the end, the only thing that solves their diet is the tinned food they buy (no. X/13).
(8) Many young patients with wound care have already seen what is good and what is not. Now you have to be more... tactful, in explaining the procedure (no. Y/17).</td></tr>
<tr><th>Major theme 2: Absence in the organisation of care</th><th>Major theme 3: Influence of gender on care</th></tr>
<tr><th>Minor theme 2: Home visits without notice</th><th>Minor theme 3: Gender and attitudes</th></tr>
<tr><th>Older women</th><th>Primary care nurses</th></tr>
<tr><td>(9) Well... they call me. And I have an appointment with the hairdresser. What do I tell the hairdresser now? That I'm not going? And what do I say to the nurse? Do not come? [she laughs] Yeah, I question, I call into question (no. 1).</td><td>(16) When a diabetic man comes here, I usually tell him, tell him to come with his wife too, because she is also the one who... (no. X/10).
(17) [Referencing (16)] Who is the one who cooks the meal for him (no. X/13).</td></tr>
</table>

(10) [Interviewer asks referencing (9): and what do you do?] Well, go to the hairdresser's, because I feel fine and don't need the nurse right now... And I need the hairdresser's because I'm going out. And I decide to go to the hairdresser (no. 1). **(11)** No, the nurses come directly, and if I'm not there, well, the little angels leave. I can't demand an hour from them because they have much work (no. 4). **(12)** No, sometimes she comes because she had to; she always had a fixed day, the last two days of the month she always came. And she no longer called; she showed up... Oh, [she names the nurse], how are you coming and not... "Don´t you know already that I come these days?" (no. 6). **(13)** [Referencing (12): and do you tell the nurses what you prefer...?] Well, I´d prefer that she reports me because since I'm alone, sometimes I'm in a housecoat, sometimes I'm... [she laughs] (no. 6). **(14)** Since I am alone here, she comes when she can. And now with more reason since a few of them have gone on holiday... (no. 7). **(15)** No, she usually calls me and tells me, "Look, I'm going to come in". Well, okay, that´s it, I know she's coming, well... I'm here ready, no worries (no. 8).	**(18)** But maybe I have a more paternalistic attitude than my colleagues, and I would often like to get rid of it, but I don't know. I don't know why I don't know how to say no to people either. Everything they blame me, they trick me, and I say yes. So that leads to much sleep being taken away, but oh well. So there are things that I know I'm not doing well (no. Y/17).
Major theme 4: Ineffective communication: opposing attitudes	
Minor theme 4: Do Not Disturb wish and confidence fluctuations	**Minor theme 5: Frustrated attempts to reach the older women**
Older women	**Primary care nurses**
(19) If I feel bad, I count on my sister. That´s it. I have more confidence in her (no. 1).	**(29)** Many say, "their nurse had to tell the patient to wash". And you say... "let's see. Do I tell him...? How do I tell him?"

(20) I say many times, I think for myself. (...) I think so. I think about it to myself, but not to... tell anyone (...) But, yes, I had to say to the nurse (no. 1). **(21)** If she [the nurse] has to do something else, that's it, and she knows that I'm cared for, that I have a lady, that I'm not alone (no. 2). **(22)** It seems... I don't care. But since I have no problems... What do I say? [she laughs] (no. 2). **(23)** I tell her [the nurse] often that the afternoons seem very long for me (no. 2). **(24)** It makes me very tired of that. It is because I say the nurses have their work, they have their check-ups, their things and I am not going to spoil them (no. 3). **(25)** I don't want to bother my children either. And when something hurts me half the time, I don't even tell them. (...) Because I don't want them to suffer! I'm suffering a lot... (no. 3). **(26)** Never. No, no, it's just that I've never told the nurse. If she changes the visit or whatever, she'll know why. “Don't you have it... like this...?” With love [clarifying in what tone the nurse says the previous]. “Haven't I told you I go on the last two days of the month? On the 24th and 25th.” And I don't... I have no complaint that she doesn't tell me or... I don't even try to say to her or ask her. I let her do it. Because she is worth a lot. Much. I don't ask her anything; she is doing... Going up, going down the day she can, and the day she can't, she doesn't come, and nothing happens (no. 6). **(27)** I let her do it, come on as if she were my mother (no. 6). **(28)** It seems that... refusing her job when she takes it like this... If she takes those pills to me, I need them. And when I Well... Sometimes... and if you tell him, he gets offended. And the wife asks for another nurse because she says I made her see that she did not take good care of her husband (no. X/11). **(30)** You go to their house, and that´s tough already. “Where does that carpet come from?” They tell you the story of that carpet. That she brought it from... “Excuse me? You´re going to take it away? Why? This furniture... what? My husband and I put it up, this piece of furniture here isn´t going anywhere...”. But look, the walking frame does not fit. Well, I'm left without a walking frame! But I don't remove that piece of furniture or the carpet [she laughs] (no. X/11). **(31)** The problem is with them [the older women]; of course, you intervene! Another thing is... what they want... (no. X/11). **(32)** A woman, one hundred years old, living alone, with her perfect head. She manages her things, goes to the field on the arm of the caregiver, and has a caregiver in the morning and another at night. And her legs were the size of; I don't know... like a column. And you say, “What about the diuretics?” “I take half”... Come on... (no. X/13).

don't need them, she tells me to leave them there [the older woman points out a box] (no. 6).	
Major theme 5: Active listening and work overload: a privilege	
Minor theme 6: No time for active listening	**Minor theme 7: Active listening as a privilege**
Older women	**Primary care nurses**
(33) Neither one thing nor the other. Sometimes they listen, and other times well... Or they think they see me better, well, and... (no. 1). **(34)** She says she also has to attend to many people. She says, "It's just not you alone, but... it's another, another, another. One day I dedicate to one, another day I dedicate to another" (no. 2). **(35)** Of course, I don't think she [the nurse] won't listen to me. That everyone listens, right? Although later they say, look, this is how it is, it is like that, and it's over (no. 5). **(36)** Even if she doesn't want to, she has to listen to me, whatever I tell her, right? And she comes running, and maybe she can stop; if I talk to her about anything, the woman should listen to me (no. 5).	**(37)** It´s not always possible because there are many, and they want you to be with them all the time. You can't satisfy everyone (no. Y/15). **(38)** Of course, they ask. People demand to listen. We all require listening. And we also like to listen to each other. (...) Patients are the same everywhere. It is the same whether they are rich, poor, or... People demand much listening. I notice that. Do we give it to them? When we can. When we can't, we don't give it to them (no. Y/17).
Major theme 6: Decision making and work overload: a form of vertical power	
Minor theme 8: No time to decide	**Minor theme 9: Imposition over the decision**
Older women	**Primary care nurses**
(39) I hardly talk to her. I don't speak. After all, she doesn't have much time because she has... It's just that people who come like this don't give you time to talk to them because you entertain them (no. 5). **(40)** I let her do what she says. "Oops, well, today I'm not going to take your blood pressure". She doesn't like to do that very much because she knows I have it high and I... Well, it worries me... and it raises a lot. And she has a hard time	**(41)** So you have to get used to them a bit, and often it is true that the barrier, when you impose, but look, well, "This would come in handy", for example (no. X/13). **(42)** And now you tell her, well, first of all, don't scold her, how will you scold her? And then they don't even open their houses to you again. That is the art, too, of... for you to keep opening up and see if any habit changes (no. X/13).

lowering it. What she does many times is not take it so as not to upset me, so as not to worry me, but she has suffered it (no. 6).	**(43)** I believe that the changes come from that. Well, they fall, and they are the ones who find themselves with a broken hip, and the world already decides for them. They stop deciding (no. X/10).
Major theme 7: Participation, work overload and personal characteristics	
Minor theme 10: No time to participate	**Minor theme 11: To wish is not always being able to**
Older women	**Primary care nurses**
(44) I am, of course, a woman, not because I want to sell myself a little problematic, you know? I adapt to... [the situation] (no. 3). **(45)** No, because this woman **[**the nurse**]** is very busy, and you can't say... What am I going to say? If this woman... "We have a mess; such a mess...". Of course, they all come running (no. 5).	**(46)** Sure, of course, we usually ask... (no. X/12). **(47)** We inform... They are told (...) You can try to negotiate, but they don't change much either... their behaviours and minds (no. X/11). **(48)** The objectives of Virginia [Henderson], the care plans, the individualised attention plans... It's all that they take care of themselves, themselves, but... (no. X/11). **(49)** You make her participate: at least make her aware of her limitations, of what would be suitable for her (no. X/13). **(50)** Because you can't tell them that they're doing it wrong. They have already fallen, tho. "And you tell me this?" Because you can't tell them, "This must be removed". We also enter like this many times. "This goes out". And you know... sometimes they listen, those fearful do listen. [she laughs] So that the nurse doesn't scold the patient when she goes back [she laughs] (no. X/13). **(51)** It´s complicated. We are talking... we are talking about communication and human relationships. So you have to be even more careful if you want habits to be changed (no. X/13). **(52)** Also, it's still an agreement between them [the older women] and us; you can't tell them everything they have to do if they

	don't like it because if they don't, they won't make any changes. So, you have to come to an agreement (no. X/10). **(53)** There are other things, we check vital signs, the medicine chest, “Let's see what it has”, and, come on, I don't know about your [referring the other nurses] case, but in many cases, they show you what they want you to know, and not what they really have (no. Y/14).
Major theme 8: Normalised subordination of the older patient	**Major theme 9: Moral authority of the nurse**
Minor theme 12: Asking for help is a form of abuse of power	**Minor theme 13: Professional pride**
Older women	**Primary care nurses**
(54) I don't abuse anyone or anything (no. 2). **(55)** I have nothing to do. I don't have to force her to do anything (no. 2). **(56)** No, because I tell you this, I understand that they have much work and there are very few people. Her work, you realise, that she not only works there, in the office, but then she has a home visit, another visit, another old one, another older one... (no. 4).	**(57)** Here we are, the oldest, and we´ve worked for many years. We have had an outstanding school. (...) I will not tell you that it is one of the best because it sounds pedantic, but it has given us a reasonably good job. (...) We are trying to convey this to the young nurses who have come recently (no. Y/17). **(58)** It also counts not only the nurse but the team. If you're a good nurse, but then the doctor you're dealing with is a little b******, huh? Who goes to... to the nurse, meh [she makes a derogatory gesture], that throws you down a lot. (no. Y/16).
Major theme 10: Time for giving proper attention and work overload: a frustrated wish	
Minor theme 14: I want them to spend more time, but they can't	
Older women	
(59) Of course, I would like that! But since she comes with... [she laughs] With that bit of time, she has to go from here to there... (no. 3). **(60)** No... I know they [the nurses] have much work. You know they've been screwed over enough by others. (no. 4). **(61)** No, not me, because the woman comes running! I open that door [she points out the entrance door] for her so she doesn´t lose time. She has to visit another, and then she has to go there... she says, “We have blood to collect today”. And as she comes, “Oh, oh! Today I come quickly, what a load I have today” (no. 5).	

(62) She has never told me, “I can't go”. No, she's coming. More time, less time. “Oh, I have to go because I'm in a hurry. I’m in a lot of…” She's always very loaded. And she consults from here to the doctor (no. 6).

(63) She is very loaded. She is very interested [in the sense that the nurse seems interested in the older woman’s well-being], and it doesn't bother me; on the contrary, I see her… (no. 6).

(64) Well, I understand that little angel has worked a lot… Much work. And if she must attend to several patients… “The blood, the anticoagulants, the wound care…” and so on… I don't think she has a good time for you to stop her either… (no. 9).

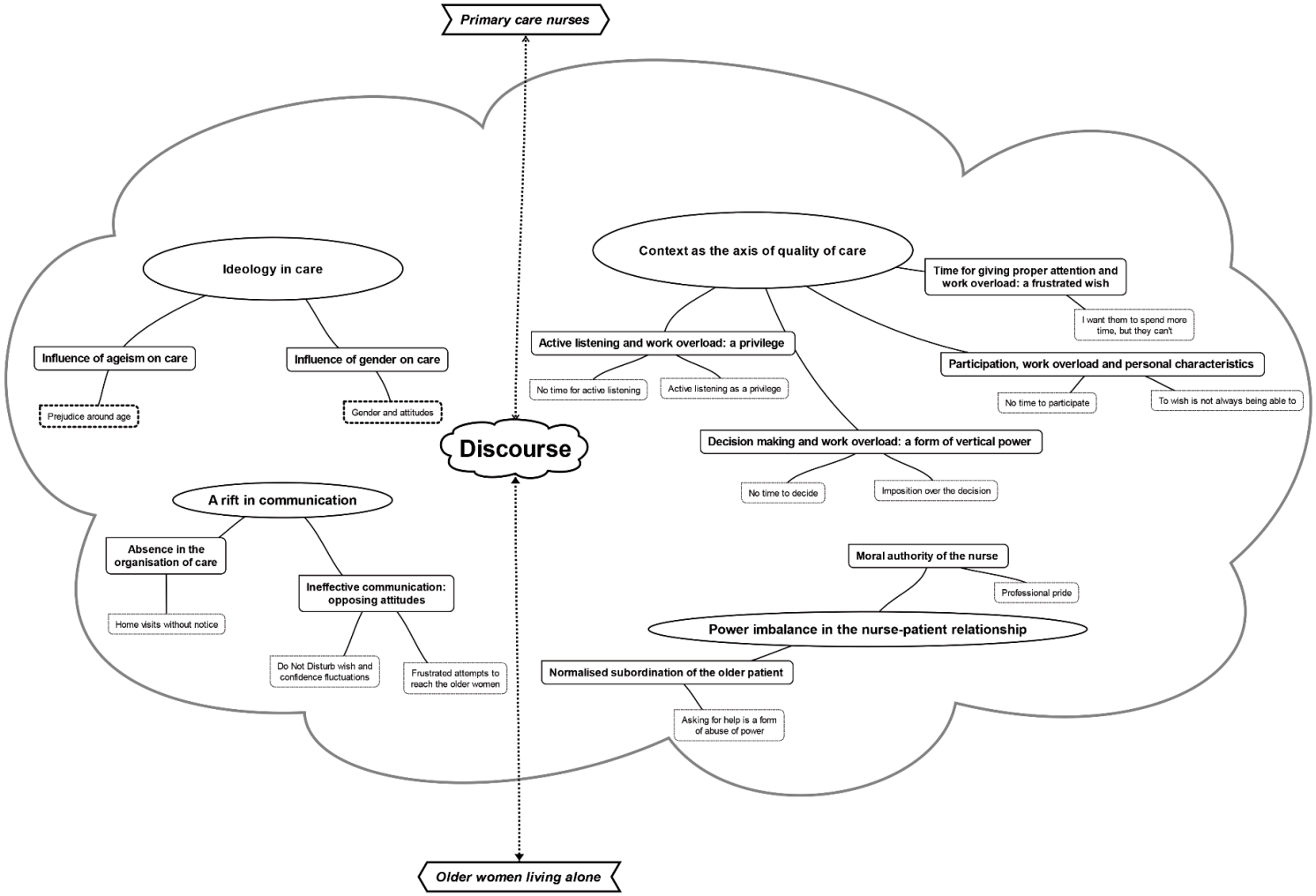

Figure 1. Discursive elements and their power relations between older women and primary care nurses.

Additional file 1. Reporting of qualitative research studies. Adapted from O´Brien et al. [26].

Items	Page and paragraph numbers stated for each reporting element
Title and Abstract	
1. Title	Page 1; Paragraph 1
2. Abstract	Page 2; Paragraph 1
Introduction	
3. Problem formulation	Page 4; Paragraph 1
4. Purpose or research question	Page 5; Paragraph 3
Methods	
5. Qualitative approach and research paradigm	Page 6; Paragraph 1
6. Researcher characteristics and reflexivity	Page 8; Paragraph 4
7. Context	Page 6; Paragraph 3
8. Sampling strategy	Page 6; Paragraph 4 / Page 8; Paragraph 1
9. Ethical issues pertaining to human subjects	Page 10; Paragraph 2
10. Data collection methods	Page 8; Paragraph 3

11. Data collection instruments and technologies	Page 9; Paragraph 2
12. Units of study	Page 8; Paragraph 4 / Page 11 Paragraph 1
13. Data processing	Page 8; Paragraph 4
14. Data analysis	Page 9; Paragraph 3
15. Techniques to enhance trustworthiness	Page 11; Paragraph 1
Results/findings	
16. Synthesis and interpretation	Page 12; Paragraph 1
17. Links to empirical data	Page 12; Paragraph 4
Discussion	
18. Integration with prior work, implications, transferability, and contribution(s) to the field	Page 21; Paragraph 1
19. Limitations	Page 28; Paragraph 2
Other	
20. Conflicts of interest	Page 31; Paragraph 4
21. Funding	Page 31; Paragraph 5

Additional file 2. Reporting qualitative research interviews and focus groups. Adapted from Tong et al. [27].

Domain 1: Research team and reflexivity	Researcher response
Personal Characteristics	
1. Interviewer/facilitator Which author/s conducted the interview or focus group?	PMA conducted all the interviews.
2. Credentials What were the researcher's credentials?	PMA was a PhD student and MSc in Health sciences research. MRR, MRJM, and SLQ were PhDs.
3. Occupation What was their occupation at the time of the study?	PMA was working as a Research Fellow at the University of Córdoba (UCO). MRR and SLQ were working as full professors at UCO. MRJM was working as an assistant professor at UCO.
4. Gender Was the researcher male or female	PMA, MRR, and SLQ are male. MRJM is female.
5. Experience and training What experience or training did the researcher have?	PMA had experience in qualitative research from previous works. He received a Master's degree in Health sciences research from the University of Jaén (UJA), Spain. In addition, PMA has received training in advanced doctoral seminars on CDA and holds a

	postgraduate certificate in Masculinities, Gender and Equality from the Miguel Hernández University (UMH). He also gave teaching lectures during his fellowship.
Relationship with participants	
6. Relationship established Was a relationship established prior to study commencement?	There was no previous relationship with any interviewee since the interviewer of the research team knew them at the time of data collection. PMA had a prior relationship with the rest of the group. MRR and SLQ were their doctoral thesis supervisors; MRJM was a colleague from the department.
7. Participant knowledge of the interviewer What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	PMA informed the participants that the research project belonged to a thesis project of PMA. The researcher told the older women and primary care nurses that his purpose was to discover how situations of active listening, shared decision-making and participation in care developed within older women-primary care nurse relationships. When the participants asked questions about the project, they were answered by both researchers.
8. Interviewer characteristics	The principal interest of PMA in the topic was based on his desire to focus the thesis project and future research on situations of social

What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	injustice, imbalance of power, and ageism in care contexts in the primary care setting.
Domain 2: Study design	
Theoretical framework	
9. Methodological orientation and Theory What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	The research paradigm for this study was sociocritical from a discursive and gender perspective. Using the CDA framework, the researchers had an approach to possible social injustice and discrimination to locate care failures and highlight areas for improvement in the care from health services. Having a gender perspective, the researchers could have an insight into how these power relationships are shaped in older women and female primary care nurses. This study analyses the power relationships between older women living alone and primary care nurses attending them at home. We employed linguistic analysis concerning discourses to understand older women and primary care nurses´ interpretations of the phenomena studied.
Participant selection	

10. Sampling How were participants selected? e.g. purposive, convenience, consecutive, snowball	The article explained the sampling method, and all approached older women and primary care nurses agreed to participate.
11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email	All study participants were approached face-to-face with help from nurse care managers and referral nurses who reached the older women. In the case of primary care nurses, a face-to-face approach was held with assistance from nurse care managers.
12. Sample size How many participants were in the study	In total, nine semi-structured interviews and two focus groups were conducted. The interviewees were older women who lived alone in their homes; primary care nurses who attended to older women with nursing home services.
13. Non-participation How many people refused to participate or dropped out? Reasons?	None of the participants who were asked to participate refused to be part of the study or withdrew from it at any time.
Setting	
14. Setting of data collection	The interviews took place at the participant's preferred location. This location was their home for older women. Indoor and conditioned

Where was the data collected? e.g. home, clinic, workplace	enclosures in their respective health centres regarding primary care nurses.
15. Presence of non-participants Was anyone else present besides the participants and researchers?	Caregivers were also present at the interviews with participants 4, 6, and 7.
16. Description of sample What are the important characteristics of the sample? e.g. demographic data, date	All participants´ characteristics are described in Tables 2 and 3.
Data collection	
17. Interview guide Were questions, prompts, guides provided by the authors? Was it pilot tested?	The authors provided the interview guides as additional files to this article. Considering the dynamic nature of the focus groups, the interview guide topics were used as a starting point for them. The list of topics was adjusted to each situation´s uniqueness throughout the research interview phase.
18. Repeat interviews Were repeat interviews carried out?	Repeated interviews with the participants were not conducted. As for the patients, this was due to their multimorbidity and because many reported their state of fatigue concerning the realisation of interviews.

If yes, how many	As for the primary care nurses, this was due to their difficulties in joining again.
19. Audio/visual recording Did the research use audio or visual recording to collect the data?	All interviews were audio recorded with the participant's verbal and written consent. The recordings were stored on PMA computers because he was responsible for data analysis. Only he had access to this data.
20. Field notes Were field notes made during and/or after the interview or focus group?	The audio recording was accompanied by a reflective field notebook which included observations and impressions that were not recorded, such as the non-verbal communication of the participant. It contained reflections through a self-hermeneutic process during the study as well. Field notes were used in the analysis of the results afterwards.
21. Duration What was the duration of the interviews or focus group?	The time of the semi-structured interviews was approximately 60 minutes on average. The time of focus group X was 50. The time of focus group Y was 70 min.
22. Data saturation	Data saturation was discussed with the research team.

Was data saturation discussed?	
23. Transcripts returned Were transcripts returned to participants for comment and/or correction?	Due to various reasons (such as the limitations in the reading of most of the patients due to medical or literacy issues; a state of exhaustion after the completion of the interviews), the transcripts were not returned to the older women for comments or feedback. The transcriptions were not returned to the primary care nurses because of unavailability.
Domain 3: Analysis and findings	
Data analysis	
24. Number of data coders How many data coders coded the data?	PMA performed the CDA. SLQ supervised the analysis alongside MRR.
25. Description of the coding tree Did authors provide a description of the coding tree?	No coding tree was used. The themes were derived from the CDA. The authors provided narrative and visual development of this process in the article.
26. Derivation of themes Were themes identified in advance or derived from the data	The themes were derived from the data and were discussed and agreed on by

	all the authors.
27. Software What software, if applicable, was used to manage the data?	SimpleMind Pro was the software tool for managing the data visually.
28. Participant checking Did participants provide feedback on the findings?	Due to several reasons, as explained at number 23, there was no feedback from the participants on our findings after the interviews or focus groups.
Reporting	
29. Quotations presented Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	The results section is illustrated with speech acts as quotes from the participants. Each quote is identified with a participant number.
30. Data and findings consistent Was there consistency between the data presented and the findings?	According to our assumption, the data presented in the study and the results that emerge from them are consistent.

31. Clarity of major themes Were major themes clearly presented in the findings?	The major themes are present in the results section of our article. Each theme is assigned a different heading.
32. Clarity of minor themes Is there a description of diverse cases or discussion of minor themes?	The minor subthemes are described along with the major themes, accompanied by specific quotes for each one.

Additional file 3a. Interview guide for older women.

Preliminary questions

1. How has your experience with nursing home care been?
2. Do you think they somehow treat you differently because of your age?
    a. [Yes] In which terms?
    b. [No] Why not? **Reasons**.

Appointments

3. When arranging an appointment, do nurses take you into account to establish the time slot for visits? [*care organisation*]

Nursing care services

4. Do you think the nursing care services you receive are those you really need? [*convenience*]
    a. [Yes] Do you receive those nursing care services when you need them? [*timely*]
    b. [No] Why not? **Reasons**.
5. Have you expressed your opinion regarding the nursing care services you receive or the treatment you take?
    a. [Yes] In which situations?
    b. [No] Why not? **Reasons**.

Nursing home visits

1. Do the nursing home visits adapt to your daily life/ lifestyle? [*balance*]
2. Do you consider the nurses to spend the necessary time you need with you? [*dedication*]
    a. In case of not: **Reasons**.
3. Do the nurses attend to any extra tasks you ask them in case of need?

a. In case of not: **Reasons**.

Preferences expression and shared decision-making situations

1. Have you chosen something or decided something regarding your care?
    a. [Yes] In which situations?
        i. Have you been able to do that the way you wanted to? [*coincidence*]
    b. [No] Why not? **Reasons**.

Active participation situations

1. What is for you "to engage in your care"?
2. Do you think you engage as a patient in the nursing care services you receive?
    a. [Yes] In which situations?
        a. Did you want to engage then? And in that way? [*coincidence*]
    b. [No] Why not? **Reasons**.

Professional behaviours

1. When you have any preference or think about something related to your health condition: how is it to tell the nurses?
    a. [If easy] How do you do it?
    b. [If difficult] Why? **Reasons**.
2. Do you think the nurses listen to you if you want to share something with them?
    a. [Yes] Do the nurses follow your decision to be made?
    b. [No] **Reasons**.
3. Do the nurses do everything for you or encourage you to do something regarding your care? [*taking advantage of capabilities*]

Additional file 3b. Interview guide for primary care nurses.

Preliminary questions

6. How has your experience with nursing home care been?
7. Do you think you somehow treat older patients differently?
    a. [Yes] In which terms?
    b. [No] Why not? **Reasons**.

Appointments

8. When arranging an appointment, do you consider the older patient to establish the time slot for visits? [*care organisation*]

Nursing care services

9. Do you think the nursing care services you give are those the older patients really need? [*convenience*]
    a. [Yes] Do you think you give those nursing care services when they need them? [*timely*]
    b. [No] Why not? **Reasons**.
10. Have you allowed the older person to give their opinion regarding the nursing care services you provide or the treatment they receive?
    a. [Yes] In which situations?
    b. [No] Why not? **Reasons**.

Nursing home visits

4. Do nursing home visits adapt to older patients´ daily life/lifestyles? [*balance*]
5. Do you consider you spend the necessary time older patients need with them? [*dedication*]
    a. In case of not: **Reasons**.
6. Do you attend to any extra tasks older patients ask you in case of need?

a. In case of not: **Reasons**.

Preferences expression and shared decision-making situations

2. Have you allowed older patients to choose or decide about their care?
    a. [Yes] In which situations?
        i. Have they been able to do that the way they wanted to? [*coincidence*]
    b. [No] Why not? **Reasons**.

Active participation situations

3. What is for you "to engage in care"?
4. Do you think older patients engage in your nursing care services?
    c. [Yes] In which situations?
        a. Do you think they wanted to engage then? And in that way? [*coincidence*]
    d. [No] Why not? **Reasons**.

Professional behaviours

4. How do you think it is for older patients to tell you something?
    a. [If easy] How do they do it?
    b. [If difficult] Why? **Reasons**.
5. Do you think you listen to older patients when they want to share something with you?
    a. [Yes] Do you follow their decision to be made?
    b. [No] **Reasons**.
6. Do you do everything for the older patient or encourage them to do something regarding their care? [*taking advantage of capabilities*]

Additional file 4. Trustworthiness criteria for qualitative studies. Adapted from Lincoln & Guba [31].

Lincoln & Guba's trustworthiness criterion	Techniques used for ensuring study quality, according to Lincoln & Guba	Researcher response
1. Credibility	1.1. Member checking	During and at the end of the interviews and focus groups, the interviewers repeated and summarised the participants´ answers to ask for clarification and confirmation of the researcher's interpretation of the answers. Moreover, the interviewer also asked the participants a final question about possible comments they wished to make regarding what had been said and potential topics not raised through the interviews but that they wanted to make explicit.
	1.2. Referential adequacy	The research team involved in the data collection and analytical phase maintained a constant dialogue between the analytical results and the raw data obtained. They carried out this continuous back-and-forth path to achieve appropriate adequacy and fidelity to the participants' discourses.

	1.3. Triangulation	In this study, we used data collection tools such as semi-structured individual interviews and focus groups to ensure a triangulation of techniques. Likewise, in each focus group, a different research team member played the observer role, collecting field notes so that the perceptions of several researchers could be compared. We have also ensured our results through researcher triangulation, sharing and discussing decisions and findings. The last researcher in this study, an expert in CDA, supervised the analysis process in parallel, raising the results reciprocally and agreeing with the final results.
2. Transferability	2.1. Thick description	To enable a comparison of the context of this study with others and allow its transferability, we have compiled a thick description of the characteristics of the participants, collected in Tables 2 and 3. At the same time, we have explained the setting as comprehensively as possible to facilitate a transfer of the context.
3. Dependability	3.1. Use of overlap methods	[See response to 1.3.]
	3.2. Inquiry audit	We handed over the project of this study to an expert researcher in qualitative research outside the research team of this work, who reviewed the different phases and how we conceived them. In addition, we discussed with the expert the moments of decision that would be carried out during the study.

4. Confirmability	4.1. Triangulation	[See response to 1.3.]
	4.2. Reflexivity	The research team was aware of its preconceptions about the study phenomenon. To safeguard the richness of meanings generated by intersubjectivity and avoid biases, the leading researcher carried out a process of self-hermeneutics that he periodically reflected on in a reflexive diary. The leading researcher, using a theoretical framework of inequality in power relations as a reference and a gender perspective, was aware that his personal values and commitment matched these theoretical precepts, which gave even more strength to his inquiry attitude.

Additional file 5. Magnitude of the derived qualitative findings.

	Major themes (magnitude in %)	Minor themes (magnitude in %)	Speech acts (magnitude in %)	Pattern A Major themes (magnitude in %)	Pattern A Minor themes (magnitude in %)	Pattern A Speech acts (magnitude in %)	Pattern B Major themes (magnitude in %)	Pattern B Minor themes (magnitude in %)	Pattern B Speech acts (magnitude in %)	Pattern C Major themes (magnitude in %)	Pattern C Minor themes (magnitude in %)	Pattern C Speech acts (magnitude in %)	Pattern D Major themes (magnitude in %)	Pattern D Minor themes (magnitude in %)	Pattern D Speech acts (magnitude in %)
Patients	3 (30%)	7 (50%)	34 (53%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	4 (100%)	14 (52%)	1 (50%)	2 (67%)	17 (81%)	1 (50%)	1 (50%)	3 (60%)
Nurses	3 (30%)	7 (50%)	30 (47%)	2 (100%)	2 (100%)	11 (100%)	0 (0%)	3 (100%)	13 (48%)	0	1 (33%)	4 (19%)	1 (50%)	1 (50%)	2 (40%)
Incommon	4 (40%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (75%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Intotal	10 (100%)	14 (100%)	64 (100%)	2 (100%)	2 (100%)	11 (100%)	4 (100%)	7 (100%)	27 (100%)	2 (100%)	3 (100%)	21 (100%)	2 (100%)	2 (100%)	5 (100%)

SÍNTESIS EN ESPAÑOL DE LA PRODUCCIÓN IV

En una conjunción exquisita de casualidades, mi bagaje personal y profesional en tierras extranjeras donde ejercí como enfermero durante dos años, me sirvió para contestar al último de los OE-TD: qué mejor entorno cultural diferente, como dos caras de una misma moneda totalmente distintas pero habitantes de un mismo mundo, que el noruego.

Durante gran parte de mi Tesis Doctoral, me esforcé por recoger testimonios a lo largo y ancho de mi tierra natal, España (Córdoba), y de mi tierra de acogida, Noruega (Jessheim y Våler i Østfold).

En la Producción IV, confluyen todos los caminos que llevan a un trabajo original, añadiendo un matiz tan extra como rico, donde la cultura es pieza fundamental de las relaciones de poder establecidas entre pacientes mayores noruegos y enfermeras migrantes españolas.

Así pues, el propósito principal fue el de analizar dichas relaciones en las situaciones de TDC, EP/EAP y PAC, y más específicamente, el papel del choque cultural en los cuidados de enfermería, desde la perspectiva discursiva de las enfermeras migrantes españolas. Además de ello, me propuse identificar también las diferencias entre discursos de personas mayores y enfermeras, y las representaciones sociales proyectadas a través de las estrategias discursivas empleadas.

Los resultados de la Producción IV mostraron que las situaciones de EAP fueron influenciadas por elementos tales como las cualidades personales de las personas mayores noruegas y las respuestas menos empáticas de las enfermeras

migrantes españolas, en general, percibidas en el discurso de las y los pacientes mayores, guardando cierta coherencia con la Producción II. Los discursos de las enfermeras migrantes españolas coincidieron con las personas mayores en el aspecto personal de este tipo de pacientes como barrera comunicativa.

En cuanto a las situaciones de TDC, el discurso de las personas mayores dejaba claro que en ningún momento habían disfrutado de la oportunidad de decidir, siendo algunas propensas a tener una actitud de agencia frente al proceso, y otras, una actitud pasiva. El discurso de las enfermeras migrantes dejaba claro que eran conscientes de la importancia de la TDC, pero a veces parecían no llevarlo a cabo.

En cuanto a la PAC, los discursos de las personas mayores noruegas y las enfermeras migrantes fueron al unísono, destacando una intención participativa en la mayoría de las y los pacientes, y un respeto por involucrarlos, por parte de las enfermeras domiciliarias.

El verdadero origen de cierto desequilibrio de poder en la Producción IV se encontró principalmente en las instituciones que organizaban la atención domiciliaria. El contexto laboral, la falta de organización de horarios de visita con las personas mayores noruegas, la falta de tiempo y la desconfianza hacia algunos miembros del equipo de enfermería, fueron consecuencia indirecta de una relación de poder silenciosa entre la institución de cuidado y las enfermeras migrantes, las últimas estando sujetas a la primera, en correspondencia parcialmente con los resultados derivados de la Producción III.

Finalmente, el choque cultural tuvo un peso importante, tanto positivo como negativo, en la forma en que las enfermeras migrantes españolas se relacionaban con su entorno, configurando así su percepción y forma de proveer cuidados de

enfermería. Los actos de habla de las enfermeras migrantes españolas revelaron que fueron profesionales culturalmente competentes.

Las representaciones sociales emitidas por las personas mayores noruegas demostraron considerarse víctimas por ser el último eslabón en las relaciones de poder; por otro lado, crearon al mismo tiempo una imagen de pacientes con dignidad y asunción de lo que quieren y necesitan.

Las representaciones sociales de las enfermeras migrantes españolas, por su parte, fueron las de un colectivo profesional comprometido con su trabajo, crítico ante situaciones concretas de injusticia social e influido por elementos culturales en su experiencia migratoria.

Finalmente, tenemos unas relaciones de poder más equilibradas entre las actrices del cuidado. Sin embargo, tenemos un triángulo de poder claro y más acentuado aún si cabe que en la Producción III, donde las personas mayores noruegas ocupaban un escalafón de poder menor que las enfermeras migrantes españolas que, a su vez, estaban simbólicamente des-empoderadas por el sistema gestor de cuidados domiciliarios. Igualmente, la cultura se erigió como elemento moldeador de experiencias vitales y discursos a través del choque cultural sufrido por las enfermeras migrantes, siendo una huella vital que transformó su realidad y su manera de concebir los cuidados, además de la forma de comunicarse con sus pacientes mayores (**Figura 10**).

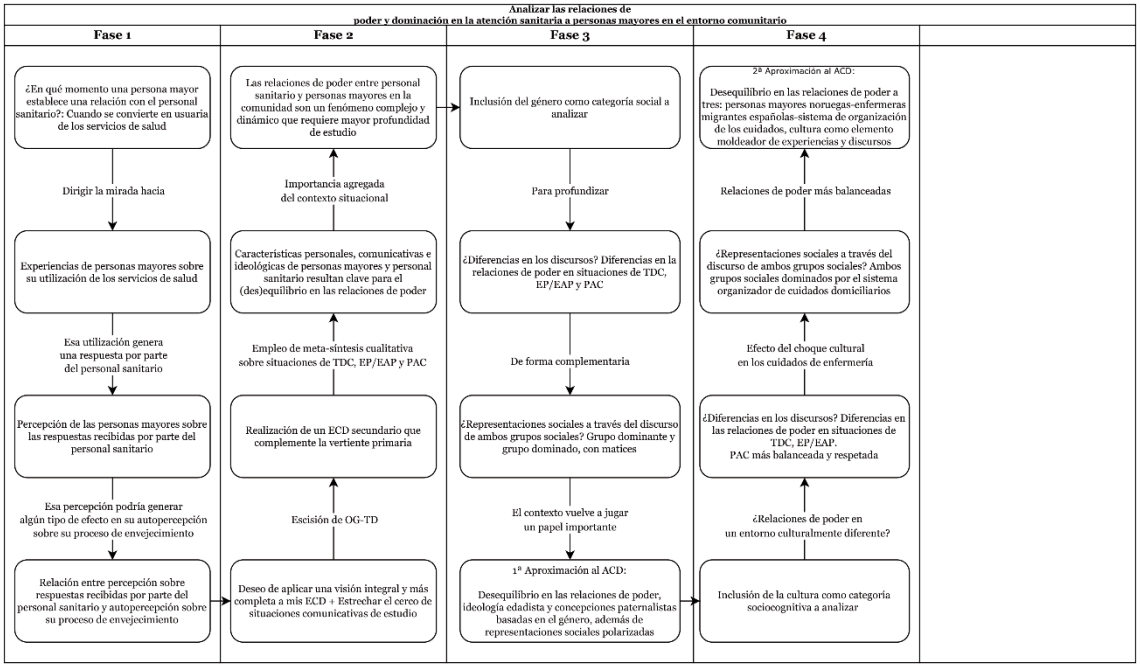

Figura 10. Hoja de ruta de la Tesis Doctoral hasta la Fase 4. Elaboración propia

IV. Analysing Power Relations among Norwegian older patients and Spanish migrant nurses in Home Nursing Care: A Critical Discourse Analysis approach from a Transcultural perspective

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Title

Analysing Power Relations among Norwegian older patients and Spanish migrant nurses in Home Nursing Care: A Critical Discourse Analysis approach from a Transcultural perspective.

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ABSTRACT

Power relations in care are the link between patients and nurses regarding communication and the ability to act in this context. It can be affected when there is cultural interference between members, putting mutual understanding at risk in healthcare situations. This study analyses power relations in healthcare situations between Norwegian older patients and Spanish migrant nurses regarding active listening, shared decision-making, and patient participation. We realised a hermeneutical study endorsed in critical discourse analysis framework from a transcultural perspective. A purposive sampling included Norwegian older patients living alone and Spanish migrant nurses working in Norway. Eleven face-to-face semi-structured interviews were conducted with older patients and four via videoconference with migrant nurses. The analysis followed hermeneutic considerations by Crist & Tanner and linguistic analysis. Shared decision-making and active listening situations sometimes showed a power imbalance that negatively influenced Norwegian older patients. However, Spanish migrant nurses were also conditioned by care organising institutions. This power triangle negatively affected the relationship between the older patients and migrant nurses, resulting in a lack of communication, personnel, time and trust. The migratory experience influenced the care provided by Spanish migrant nurses, shaping a series of cultural competencies acquired through the migratory process.

Keywords: Norwegian older patients; Spanish migrant nurses; Nurse migration; Active listening; Shared-decision making; Patient participation; Transcultural nursing; Cultural competency; Critical Discourse Analysis

INTRODUCTION

Nursing is the most significant health professional group in the world; that is why nurses represent a crucial figure in providing quality and good care, from a socioeconomic point of view, in a globalised and industrialised society where needs urgently have to be satisfied [1]. According to the state labour market report for 2021 in Spain, nursing was one of the occupations with the most difficulty filling positions, and whose temporary rate in labour contracts was 92.84%. Of 8,836 registered contracts, 8,105 were of temporary duration, giving us a sample of the high percentage of instability in Spanish nursing employment [2]. Regarding the type of contract, over the last 10-15 years it has been observed that the trend in temporary contracts and part-time contracts has been increasing. In the last two years, temporary contracts have maintained very high figures [2]. A recent multicentric cross-sectional study in Spain by Acea-López et al. [3] showed that nurses with a temporary contract suffered from a high burnout rate and high levels of emotional fatigue, depersonalisation and lack of personal fulfilment. Regarding migration, 16.13% of participants considered leaving the country for France, Germany, Ireland, Norway, the United States or the United Kingdom. Therefore, labour conditions, job uncertainty and professional development are central elements in the motivation for Spanish nurses to leap to work abroad [4–6], thus establishing Spain as a net supplier of nurses to foreign countries. This is not exceptional in the scientific literature, which has shown that the migration of health professionals in Europe has a long history [7]. However, they are not exempt from fears such as rejection or discrimination when working abroad in the host country [8].

The counterpart in these labour conditions is Norway, which has been experiencing diminishing health workers for years, whose vacancies are sometimes barely filled. Official statistics in Norway suggest that in 2035, there will be a need for 28,000 nurses, further accentuating this coverage deficit [9]. It is then that qualified immigrant caregivers represent an increasingly influential group in mitigating this care deficit [10]. Despite immigrants' increasing role and presence in health care work throughout Norway, more research is still needed on this group, specifically, those who provide in-home care for older adults [11,12].

In this context, where a situation of cultural vulnerability appears concerning migrant professionals, it is essential to focus these investigations on the relationship of migrant nurses with their professional colleagues and older patients, which may be resented or at least influenced by a changing cultural environment [12,13]. Several studies have been primarily concerned with showing that healthcare practices are influenced by the relationships between migrant caregivers —mainly female— and patients receiving care in domestic and institutional contexts.

In a globalised world where health meeting needs become a challenge for any nation, it is also essential to explore the ins and outs of the relationships of care in the community, which is why this study is presented as a transcultural window to glimpse the characteristics of these relationships increasingly present in the international reality of care. These relationships include nursing practices and professionals as relational identities strongly influenced by social, cultural, economic, and political circumstances [14,15]. These nursing practices play a critical presence in the professional identities of nurses and discover hierarchies,

power relations, and empowerment in particular cultural healthcare settings [16,17].

This study focuses on analysing power relations in health care provided by Spanish migrant nurses to Norwegian older people in the community. In our study context, we understand power relations as the phenomenon that modulates the execution of shared decision-making, the expression of preferences and the active participation of Norwegian older patients in the care provided by Spanish migrant nurses. The hierarchical situation both members occupy in this healthcare relationship and the different "ability to act" [18] of both figures concerning these three components may influence this phenomenon. Addressing the relationship between older people and nurses is, therefore, essential within primary care settings [19]. To this relationship must also be added a robust communicative component, which intervenes in the modulation of the expression of preferences by older patients and in the active listening from migrant nurses, leading to the possible appearance of situations where decision-making takes centre stage [20]. So, the objectives of this study were to analyse power relations through the description of situations about active listening to preferences, shared decision-making, and participation in care between Norwegian older patients and Spanish mi-grant nurses in the community; to identify imbalance in the perception of these situations through Norwegian older patients and Spanish migrant nurses discourse; to explore the effect of culture shock experience on the nursing care through Spanish migrant nurses discourse, and to highlight the social representations conveyed by Norwegian older patients and Spanish migrant nurses shaped by their discursive strategies.

MATERIALS AND METHODS

Design

We conducted a hermeneutic interpretative study endorsed in the critical discourse analysis (CDA) framework of discourse studies (DS) with a transcultural perspective. The hermeneutic design allowed us to discover, through an interpretive process, the meaning of the life experience of the study participants [21]. Language is a powerful tool [22], as is the discourse, understood as a means of reproducing inequality [23]. This inequality can lead to an imbalance of power in the relationships between Norwegian older patients and the Spanish migrant nurses who care for them. In this way, the discourse can influence the appearance and development of the study phenomena. To analyse that potential influence, we adopt the academic-critical perspective of the CDA [24]. We take Van Dijk's model of power relations as a reference —considering his socio-cognitive approach [25]— together with Foucauldian elements such as oppression and society [23,26]. We decided to confer a transcultural perspective to this study through the Campinha-Bacote notions of cultural competence in healthcare delivery [27]. We used this author's transcultural framework as a reference because we understand cultural competence in nursing as a process, not a consequence. This process encompasses the migrant experience that we bore in our study. In detail, we consider her definition of cultural awareness, cultural skill, cultural encounters and cultural desire as a whole, which cover the process by which nurses attempt to provide quality care while acquiring the ability to work in a culturally different environment and care for a group of patients sharing that foreign cultural context. In other words, to become culturally competent healthcare professionals.

Furthermore, we wish to give this article a detailed and complete study report. To achieve that, Table S1 contains the 32 items that comprise the COREQ checklist for original qualitative studies [28]. For an adequate presentation of the information on sex throughout the present study, we have followed the considerations reflected in the SAGER guidelines [29].

Setting

Data collection of Norwegian older people was conducted in two different nursing home facilities in Norway. A nursing home facility provides services for the patients who live at home to maintain or regain the ability to perform activities they can master. These services can cover coping with everyday life and rehabilitation, use of welfare technology, help with self-care, medication management and wound treatment [30]. The first of them was in Jessheim. Jessheim is a town in Ullensaker municipality in Viken and had 23,000 inhabitants in 2022 [31]. Jessheim is an administrative centre in Ullensaker municipality in Øvre Romerike. Of the total population in this town, 1,189 people were men aged 67 or older, while 1,541 were women aged 67 or older [32]. The second was in Våler. Våler is a village in Våler municipality in Innlandet, with 1,138 inhabitants in 2022 [33]. Våler is the administrative centre in the Våler municipality. Of the total population in this village, 165 people were men aged 67 or older, while 208 were women aged 67 or older [32].

Study participants

We performed purposeful sampling according to concrete selection criteria [34], as Table 1 shows. Regarding Norwegian older patients, we decided to use criteria A and B because they are characteristics that intensify the concept of vulnerability in this group and are a reasonably general profile of older patients

targeted in nursing home services in Norway. Therefore, it would facilitate the transfer of this context to other studies. Regarding the Spanish migrant nurses, we decided to use criteria F and G because we considered it a reasonable time from which to have a varied range of experiences framed in the different phases of culture shock that would provide us with a greater depth of information on the migrant experience in Norway and in-home nursing services.

Table 1. Selection criteria for Norwegian older adults and Spanish migrant nurses.

	Norwegian older adults	**Spanish migrant nurses**
Inclusion criteria	**D.** 75 years old or older. **E.** Living alone at home. **F.** Receiving nursing home care services at the time of the study.	**I.** Having at least six months of work as a nurse in Norway. **J.** Having at least one month of uninterrupted work experience as a community care nurse in Norway. **K.** Having performed nursing home care visits to Norwegian older patients as part of the community care nursing tasks.
Exclusion criteria	**F.** Suffering from cognitive impairment. **G.** Suffering from a terminal illness.	**I.** Not having made a minimum of one nursing home care visit to Norwegian older patients in at least one month worked as a community care nurse.

Recruitment of participants

Regarding recruiting Norwegian older patients, the first researcher met with the respective nurse supervisors at each nursing home centre to explain the research project and share the selection criteria with them. After this, the nurse supervisors, with the help of the nurses employed at the centres, provided potential older participants with an information booklet containing the fundamental concepts of the project available in Scheme S1. Those older adults interested in receiving more information told the nurses and those nurses notified the first researcher. After receiving further details, the older people who agreed to participate were subsequently contacted to arrange the interview at a place and time agreed upon by consensus. The site was, in all cases, the older person's home, according to their wishes.

Regarding recruiting Spanish migrant nurses, a snowball sampling was followed, starting with a Spanish migrant nurse that the first re-searcher knew beforehand, knowing that she met the selection criteria.

Interview guide

Concerning the interview guide, the first researcher prepared a preliminary script for each group of participants. These scripts had their pilot test with three Norwegian older patients and three Spanish immigrant nurses. We decided to do this to calibrate its content and assess whether we were approaching the interview correctly. These primitive interviews were not incorporated into the final corpus of the study. The reasons for their exclusion were, in the case of the older Norwegian patients, being slightly younger than 75,

in the case of Spanish migrant nurses, not having worked in home nursing services.

Once the final guide was calibrated, interviews were conducted, on the one hand, with older patients and, on the other, with Spanish migrant nurses (see Scheme S2a & S2b).

Data collection

In the case of Norwegian older patients, we conducted eleven semi-structured face-to-face interviews, following the discourse saturation criterion [35]. To engage in culturally sensitive interview practices that would enrich the data and solve possible misinterpretations of the study phenomena in the specific cultural context of nursing home visits in older Norwegian patients, we focused on the cultural context and the interviewer-interviewee encounter [36]. This was possible through an assumption of sociocultural elements that shaped the meeting, such as the cultural identity of the interviewer and the Norwegian older patients, the space where the interviews were conducted (their homes) and the resulting intersection between all these elements [37]. These assumptions were reflected in the first researcher´s hermeneutical diary.

In the case of Spanish migrant nurses, we performed four semi-structured interviews via videoconference through the Zoom platform. To ensure optimal ethical and methodological considerations during the interview process with the Spanish migrant nurses, the first researcher followed the practical implications of Pilbeam et al. [38]. We chose to use semi-structured interviews as a tool because it gave us some critical points to pivot for data collection; simultaneously,

the depth of the participants' discourses was not limited [39,40]. The interviews were conducted between November and December 2022.

Firstly, the interviews began with preliminary and open questions so the participants could respond freely and convey their first impressions. Subsequently, the semi-structured interview was progressively outlined and took a more defined orientation. All the interviews were audio-recorded and accompanied by the hermeneutical diary, which the first researcher used for complementary information, such as self-hermeneutic considerations, kinesics, and body language [41,42].

We understood the proper language translation process as essential to accurately convey participant meanings between languages and ensure qualitative research's reliability [43]. The interviews were conducted in Norwegian, regarding Norwegian older patients, in Spanish, concerning Spanish migrant nurses, which was the original and native language of the participants. Hence, our translation process began in the dissemination phase of our work in English [44]. During this process, we translated the research, so we adopted the figure of researcher-translator. For this, the first researcher translated the speech acts of the Norwegian older patients based on his previous knowledge of the Norwegian language and the notes belonging to the hermeneutical diary. Regarding the Spanish language, the first researcher also translated the speech acts of the Spanish migrant nurses since Spanish was his mother tongue. In addition, the consultation technique was carried out with a Norwegian native nurse researcher, knowledgeable of both the language and the culture [45].

Data analysis

For the analytical phase, we employed the hermeneutic analysis considerations described by Crist & Tanner [46] and linguistic analysis of the

research corpus. Regarding CDA, linguistic analysis is necessary to decode the sociocognitive relationships hidden behind the discourse of Norwegian older patients and Spanish migrant nurses. However, we maintained sight of the fact that in the case of nursing inquiry, we must consider above all the study phenomena that interact in the context of care and the subsequent complementary linguistic component [47,48]. Through CDA, we identified discursive strategies that unravel the positive representation of the self (in-group favouritism semantic macro-strategy) and the negative representation of the other (out-group derogatory semantic macro-strategy) [49,50]. These discursive strategies representations were identified by analysing speech acts that illustrated comparisons, exemplifications, generalisations, polarisations, presuppositions, and victimisations [50,51].

To carry out the approach to CDA, first, we had to find the moments that reflected situations of inequality from a critical point of view. To achieve this purpose, the research corpus was determined following the steps recommended by Bolívar [52]: (a) differentiating the textual corpus from the research corpus, (b) selecting informative material through an awareness of the basic assumptions and problems to be addressed, (c) determining the linguistic sublevels to be approached. To complete these phases, the first researcher conducted a first immersive reading of the transcripts to become familiar with the textual corpus (the participants' speech acts). After that, a second comprehensive reading was carried out to identify the discursive moments that allowed us to resolve our objectives around active listening to preferences, shared decision-making and participation in care from a prism of inequality and power imbalance. Finally, a focused reading was carried out to understand the linguistic planes of the discourse that the corpus invited to address —since within the linguistic level,

there are numerous sublevels— and thus decide the approach corresponding to the sharp fragments to analyse. After obtaining the research corpus, we chose to approach the analysis of the pragmatic, syntactic, semantic, rhetorical-stylistic and cognitive sublevels, as well as a description of the discursive strategies deployed by the participants.

Rigour and Quality Guarantee

For this study's rigour and methodological quality, see Table S2, where we detailed the guide for the reflexivity experience of conducting sensitive qualitative research as a cultural outsider, according to Joseph et al. [53].

Ethical and legal aspects of the study

We informed all the participants about the characteristics of this study before the interview through an information sheet for each participant. Informed consent to participate in this study and audio recordings were obtained by signature. We previously told participants that the data collected would be used for research purposes only and that all identifying information would be anonymised to safeguard their identity. We informed the participants about (a) the objectives of the research, (b) the guarantee of the confidential nature of personal data, (c) the custody and handling of the data, (d) the disclosure of the results of this research, (e) the possibility of leaving the study at any time and without any consequences.

On the other hand, the present study was conducted in compliance with the principles of the Declaration of Helsinki and had permission to develop from the Ethics Committee for the Province of Cordoba (Spain) (Minutes No. 283 Ref: 4118). Concerning Norway, we had approval from the Regional Committee for

Medical and Health Research Ethics in Norway (Ref: 2018/1262, REK sør-øst) and the Norwegian Centre for Research Data. The personal data obtained have been processed following the General Data Protection Regulation EU/2016/679, of 27 April 2016, and the provisions of the Organic Law 3/2018, of 5 December, on the Personal Data Protection and Digital Rights Guarantee.

RESULTS

Description of the participants

As for the older people, all were Norwegian, of whom eight were women, and three were men, with a mean age of 83 (Table 2). The Spanish migrant nurses were all white Spanish women, with a mean age of 26 (Table 3). The corresponding sociodemographic information was collected through a self-filled registration before the interviews.

Table 2. Characteristics of Norwegian older patients (n = 11).

Participant No.	Age	Sex	Home nursing services (Frequency)	Older patients´ health condition	Home setting (Urban/Rural)
1	86	Woman	Medicines delivery (3 times a day) Administration of nebulisers (4 times a day) Placement of compression stockings (once a day) Removal of compression stockings (once a day) Shower aid (once a week)	COPD Hypertension Peripheral Vascular Disease	Urban
2	89	Woman	Medicines delivery (3 times a day) Shower aid (once a week)	Hypertension Hyperlipidemia	Urban
3	87	Woman	Medicines delivery (once a week)	Hyperlipidemia	Urban
4	88	Woman	Medicines delivery (3 times a day) Administration of nebulisers (twice a day) Application of analgesic ointment for pain (if necessary)	Asthma Arthritis	Urban
5	81	Man	Medicines delivery (once a week) Irrigation for urinary catheter maintenance (twice a week)	Prostatic hyperplasia	Rural

6	91	Woman	Medicines delivery (once a week) Placement of compression stockings (once a day) Removal of compression stockings (once a day) Medication intake check (once a day)	Peripheral Vascular Disease Hyperlipidemia	Urban
7	75	Woman	Medicines delivery (once a day) Administration of nebulisers (twice a day) Lunch delivery (once a day)	COPD Smoker Coagulation disorders Malnutrition (deficit)	Urban
8	75	Man	Medicines delivery (once a week) Medication intake check (twice a day) Food intake check (twice a day)	Insomnia Anxiety Malnutrition (deficit)	Urban
9	83	Woman	Placement of compression stockings (once a day) Removal of compression stockings (once a day) Moisturising foot cream application (once a day)	Peripheral Vascular Disease	Rural
10	78	Man	Placement of compression stockings (once a day) Removal of compression stockings (once a day)	Peripheral Vascular Disease	Rural

11	79	Woman	Blood glucose levels check (twice a day) Insulin administration (if necessary)	Diabetes Malnutrition (excess)	Rural

Table 3. Characteristics of Spanish migrant nurses (n = 4).

Participant No.	Age (years)	Qualified nursing professional (years with/ or months)	Nursing professional employment (years with/ or months)	Nursing professional employment in Norway (years with/ or months)	Nursing professional employment in home care services (years with/ or months)	Workplace in Norway
12	28	6 years	4 years and a half	4 years and a half	4 years	Råde
13	25	3 years	2 years and a half	2 years and a half	1 month	Odda
14	26	3 years	3 years	2 years	1 year and 5 months	Høyanger-Odda
15	26	1 year and 7 months	7 months	7 months	3 months	Sola

Conceptual map for the synthesis of the results

Figure 1 illustrates how the discourses of Norwegian older patients and Spanish migrant nurses shape the perceived reality in the context of situations of active listening, shared decision-making, and participation in care. On the other hand, it also visually shows the interaction between the migratory experience of the Spanish nurses and the acquisition of cultural competencies regarding the exercise of their nursing profession.

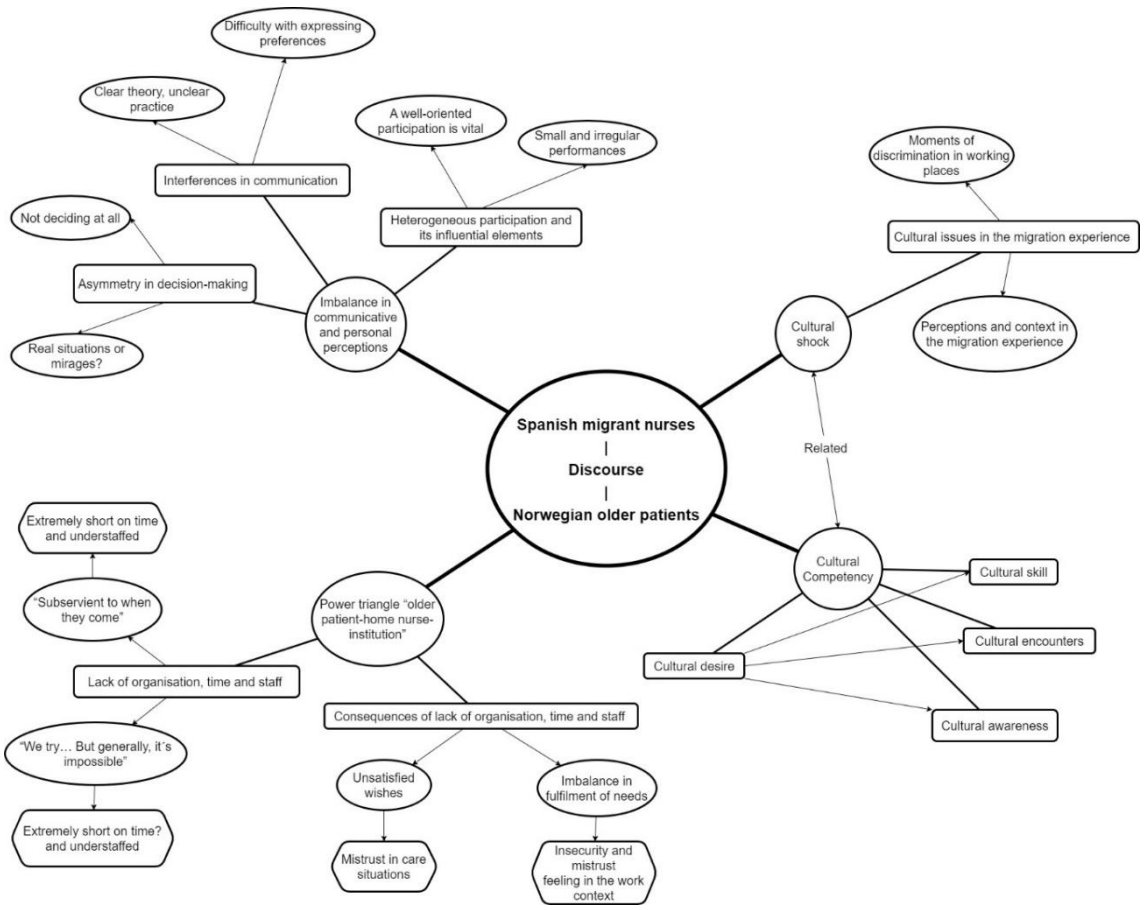

Figure 1. Discursive and power elements shaping relations between Norwegian older patients and Spanish migrant nurses.

Narrative development of the results

The results of this study show explicit representations of power imbalance as speech acts belonging to the participants' discourses. The Norwegian older patients adopted a role at times predominantly subservient about the study phenomenon, but with flashes, at other times, of personal agency and security concerning their desires and needs. On the other hand, the social representation of Spanish migrant nurses was more blurred, given their status as foreigners and the work context in which they found themselves. Spanish migrant nurses displayed empathic and holistic conceptions of care but were not always translated into a horizontal nursing exercise, sometimes influenced by their transcultural experience. According to the marked differences in their discourses, the Norwegian older patients and the Spanish migrant nurses led in communication interferences and affected the appearance of real decision-making situations.

The major themes were synthesised until a higher level of qualitative meaning was found. Then, we reached the following study patterns: Imbalance in communicative and personal perceptions, Power triangle "older patient-home nurse-institution", and Cultural shock. Next, we developed the approach to CDA orderly through the study patterns, the major themes that integrate them and the speech acts to which reference is made.

To facilitate the identification and origin of the results, we present them in Table S3 in an organised manner in the form of major themes, minor themes, and the extracts of the speech acts that comprise them. To provide an overview of how the emergent CDA results were hierarchically distributed, we also calculated in Table S4 the magnitude of the derived findings [54].

Pattern A: Imbalance in communicative and personal perceptions

This study pattern collected the results in the participants' discourses about the three study phenomena of nursing care we proposed in this work. There were communication barriers indicated by the discourse of the Norwegian older patients, which the Spanish migrant nurses also highlighted. However, migrant nurses were aware of the importance of maintaining therapeutic communication. Regarding decision-making, the situation was unbalanced to the extent that older patients declared that they had practically no decision-making moments. Spanish migrant nurses, for their part, made a distinction between moments, attitudes and personal characteristics that were vital to promoting decision-making among older adults. Perhaps within a more balanced relationship re-garding participation, the Norwegian older patients changed their dis-course towards a much more active attitude, something the migrant nurses also appreciated and clarified active participation as a crucial concept they tried to carry out whenever possible. The most used discur-sive strategies were those of exemplification and generalisation.

Major theme 1: Interferences in communication (1) – (22)

The discourse of the Norwegian older patients showed, in most cases, communicative difficulties whose origin lay in various situations. Their discourses were strongly random, depending on which nurse would visit them. Two different circumstances marked the modulation of the communicative moment; the first was the personal qualities of the professional who visited her, which invited them to communicate or not de-pending on whether the Norwegian older patients considered the professional's attitude acceptable. The second circumstance included the responses received directly or indirectly by those nurses, which caused an inhibitory effect on therapeutic communication if they

did not meet the needs of the patients. In any case, these circumstances converged in a feeling of inferiority or self-imposed contempt, something visible through a discourse full of negative pragmatic connotations, conveyed through speech acts with negative illocutionary force ("There may be someone worse", "I feel a bit guilty") or exemplifications with devaluation explanations about nursing praxis. Another reason that acted as a communicative barrier was their own personal qualities, and transitional moods, with the clear explicature that the Norwegian older people were aware of these same qualities and moods represented a barrier but apparently did not seem to do anything to remedy it. The speech act (13) was noteworthy, as it stood out from other more direct ones like the rest, since the implicature of loneliness slipped in here, possibly connecting with needing more time to talk with the nurses.

In the case of the Spanish migrant nurses, their discourse reflected an assumption of the importance of therapeutic communication with older patients. At the same time, they resorted to exemplification strategies to reinforce their arguments. The discourse of the migrant nurses also gave prominence to the personal qualities of, this time, the Norwegian older patients, so there was a certain parallelism with the older adults in the conception of personal qualities as a catalyst for communicative situations. Migrant nurses projected, through discursive strategies of intensification, that Norwegian older people notably conveyed their opinions and complaints, leaving the feeling that positive things were not considered in the same way. We highlighted the speech act (21), in which a migrant nurse left as a reflection of the implicature of what extent the fact of validating the preferences of which older adults in doubtful health contexts should prevail over optimal care. The Norwegian older patients demanded through their speech acts not to be listened to in situations of illness and request

for help, in addition to suggesting specific states of need. On the other hand, the Spanish migrant nurses gave importance to the moments of active listening. Still, they mentioned elements that make it difficult, sometimes going so far as to reconsider the extent to which it is beneficial to validate preferences unconditionally.

Major theme 2: Asymmetry in decision-making (23) – (39)

The discourse of the Norwegian older adults was overwhelmingly unanimous in not having the possibility to decide on anything in particular, despite declaring that they could do so. Within this reality, there was a division of opinions through polarised discourses, with a sector in favour of not deciding and another inclined to do so. In (30), the exemplification intensified the impossibility of deciding on something that the Norwegian older patient wanted; in (31), the use of an agency-intensifying adverb ("strongly") made the speech act gain illocutionary force to make visible the willingness to reverse the situation; the use of direct speech acts by several patients implied that the nursing professionals had not even offered sensitive moments to the decision of the older patients. Conversational discursive strategies, such as silences or laughter, were components of significant pragmatic load in the discourse of the Norwegian older patients that added a feeling of insecurity and bewilderment in the face of the possibility raised.

Concerning Spanish migrant nurses, the discourse differs according to the type of older patients to be treated. The exemplifications served as a tool to clarify that it was only in some instances when older patients were not included in the decisions. On the other hand, the partially projected social representation corresponds to a role of power using a lexicon with pragmatic connotations

("conflictive", "bosses"), but, at the same time, a lexicon and syntax constructions of an empathic nature ("you have to ask them", "I don't try to force them but to convince them"). That is why the power influence from the perspective of Spanish migrant nurses' discourse is diffuse and unclear. On the other hand, the discursive resource of using the first-person plural pronoun reflected a group identity, through which migrant nurses felt they were spokespersons for their professional group. In addition, their discourse added empathic over-tones as in (38), through which the migrant nurse considered herself an external factor by giving her opinion as an outsider narrator about the decision-making situation in the receiving country, something that reached another level in (39), in which the nurse went further and through a generalisation resource, commented that it was a usual dynamic to validate patient decisions even when they were not in their full faculties, something that has already appeared previously about active listening.

Major theme 3: Heterogeneous participation and its influential elements (40) – (58)

The discourses of Norwegian older patients were heterogeneous regarding their participation in care. A minority declared not to participate, mainly because they were tired, as in (47), where the older Norwegian patient's speech act was zigzagging and full of pauses, reflecting the disconcerting and fatigued state in which she found herself. On the other hand, most older patients showed signs of a participatory attitude through a discourse full of exemplifications related to the interventions carried out by nurses, balancing the power relationships regarding this matter. The discourses of the Norwegian older patients who did participate described situations of supervision of the material that the nurses would use,

notices about any last-minute changes, cleaning of materials or feedback on when they were available to receive the visit. Especially notable was the speech act (46), through which the patient uses intensifying resources ("absolutely") that added illocutionary force to the argument, in addition to an argumentative development that justified why she considered participating essential. In (48) and (49), the patient's desire to participate stood out, and the helplessness of being prevented by the nurses. The use of syntax parallelisms ("They don't let me get up and cut bread; they don't let me mop the floor") reinforced the patient's discursive argument, in addition to being accompanied by explanations that indicate that nurses did not only not allow her to do certain things, but also the nursing care she received should not interfere with her desire to participate.

As regards incorporating older adults into participation in their care, the discourse of the Spanish migrant nurses was practically unanimous: they recognised the right to participate, stressed the importance of doing so, the positive effect it had on older patients´ health, and appreciated that, in general, in Norway, this level of participation in the older patients is taken into account. On the other hand, through exemplifications, the migrant nurses established differentiations about which moments were sensitive for participation, focusing more on self-care and hygiene tasks; they also stated that it depended to a large extent on the cooperative attitude of the older patients, something that could be a handicap but also remediable as they got to know each patient personally. At the same time, Spanish migrant nurses highlighted the importance of asking whenever possible whether the older patients or their families. A discordant note was (57), in whose speech act the migrant nurse resorted to a generalisation resource to ensure that older patients typically let themselves be led by nurses.

Pattern B: Power triangle "older patient-home nurse-institution"

In study pattern B, we discovered that power relations were not only limited to the nurse-patient pairing but also transcended that link towards an institutional figure that exerted oppression on the working conditions of home nurses. For that reason, a "chain of power" was assembled between older patients, home nurses, and an institutional figure. The lack of collaborative organisation with the older patients and the lack of time and personnel were shared elements in the perception of Norwegian older patients and Spanish migrant nurses, in addition to describing situations of unmet needs and mistrust in the work environment. In this case, the migrant nurses referred in their discourses to the effect of cultural influence on said feelings. The predominant discursive strategies were those of exemplification, generalisation and comparison.

Major theme 4: Lack of organisation, time and staff (59) – (93)

The discourse of the Norwegian older patients reflected predominantly negative aspects regarding the organisation of the visits. Through abundant generalisation resources ("They come when it is best for them to arrive", "they come when they want", "they don't always come when they should"), assumptions were generated that pointed towards home nurses as a precise authority figure, who did not consider older people as active members to take into account. This caused discomfort in older patients through exemplification resources, reinforcing their arguments by declaring that they have come to interrupt their daily routines because of the home nurses. It was worth noting the victimisation resource used by (64), with a robust lexicon of pragmatic connotations, going so far as to declare that she was subordinate to the nurses explicitly. From the perspective of the discourses of the Norwegian older patients, the care organisation kept almost exact parallelism with the time organisation and the

lack of personnel they perceived. Almost unanimously, they used generalisation resources regarding the lack of time they believed nurses suffered, impacting the quality of care received. In (74), the enumeration resource intensified the work overload suffered by nurses, in addition to the implicature that he was not just another number for nurses but felt like one. The feeling of undervaluation is extensible among the discourses of the older patients, as seen in (78), a speech act that went further by classifying her need as unimportant, establishing a hierarchy of patients based on the activity that the nurses were going to do. It is worth highlighting the speech act (81) of great illocutionary strength, whose purpose was to make the addressee of her message aware of the precariousness in which the patient believed nurses lived, thus achieving an empathic perlocutionary effect.

Regarding the problem of coordinating visits, the Spanish migrant nurses asserted through their discourses that they tried to reconcile schedules with the preferences of the older adults. However, the conjunction "but", present in the speech acts (84) and (85), invalidated this intention, projecting an image of frustration and limitation due to the workload suffered by the home nurses themselves. The social representation emitted in this case by migrant nurses was that of professionals who were aware of the preferences of their patients but who, through no fault of their own, were unable to satisfy them. Therefore, the power relations here extended beyond the nurse-patient pairing to end up in the nurse-institution pairing. The power triangle was then the subordination of the older patients to the home nurses, which followed the subordination of the home nurses to the institution that organised everything. This power triangle was directly connected with the perception of Spanish migrant nurses regarding the lack of personnel. This element saw a continuation concerning the perception of

Norwegian older patients. The nurses' discourse used numerous exemplification resources to intensify the lack of time that affected them.

On the other hand, in (88), a migrant nurse used a comparison re-source to verify that, despite this, in her homeland, they had even less time. The nursing discourses empathised with the older patients. The Spanish migrant nurses declared they liked to spend time talking with the patients and that sometimes they could not do it —something that seemed not the best thing to do. Therefore, there were situations where care could be improved. In the speech act (93), an exemplification of the migrant nurse ventured to ensure that, in her current workplace, it was not so much a lack of time as a lack of self-organisation of the staff or even a lack of interest in certain colleagues in spending quality-care time with their older patients.

Major theme 5: Consequences of lack of organisation, time and staff (94) – (116)

The lack of time and personnel on the part of home nurses resulted in the appearance of unsatisfied needs and unfulfilled wishes on the part of Norwegian older patients. The discourses of the Norwegian older patients used numerous exemplifications of the issues they considered necessary to address, which varied. The common denominator of the requests was to receive more help, in general, and more assistance regarding health procedures with others professionals and extra support at specific seasons. An issue that deserved to be highlighted was the speech act (95). An older patient declared that she would prefer to receive a personalised-continuity-assistance during the visits so that the nurses stayed the same continuously to avoid repeatedly explaining how they should act, which was tiring.

This problem was directly related to trust issues with home nurses, which surfaced in the discourse of Norwegian older patients. Employing exemplifications using the parallel syntax (“Some don't know precisely what to do […], some fool around a bit…”), the discourses gave an account of the problem of the individual irregularity of nurses, which led to discontinuity of care. In the speech act (101), the first person plural was used, accompanied by a pragmatically charged lexicon (“We, the dependents, must have confidence”), to speak through a group identity about a great need that affected both himself and the group of older patients who received nursing services at home. At this time, the Norwegian older patient assumed a subordinate role that, from a sociocognitive point of view, outlined the dependency relationships he maintained with the home nurses. Another example of the power imbalance perceived by older patients could be found in (102), where the syntactic construction “But I'm not in that position” had the same semantic-cognitive sense of subordination. As a definitive cause of trust fluctuations, once again, we were able to find the assumption that, depending on the nurse, relationships will be more or less fluid, as in (105).

From the point of view of the discourse of Spanish migrant nurses, discursive strategies of exemplification, generalisation, and comparison were abundantly used to support their arguments. For the most part, migrant nurses considered that Norwegian older patients did not see all their needs met at all times, both from physical and psychological-emotional point of view. The psychological component was of great importance in the nurses' discourse, which was strongly affected by the lack of time to devote more attention to this plane and by perceived cultural components, which contrasted markedly with what home nurses perceived in their native country, as seen in the speech act (111). A discordant and explanatory note of the changing reality of home nursing

perceived by Spanish migrant nurses was the speech act (112), through which a migrant nurse declared that sometimes they performed services that were not necessary for older patients with the excuse of satisfying the need of the older adult's family to keep an eye on their parents.

The general mistrust was also transmitted in the environment of migrant nurses, especially from a cultural point of view. In their discourses, exemplification and stylistic resources such as metaphors ("other colleagues have let me pass the buck") were present, which endowed the arguments with illocutionary force. Entering a different work, culture and language scenario sometimes made them need more time to adapt to the environment and the patients. Added to this, they had to live with the presuppositions of other Norwegian colleagues who considered Spanish migrant nurses to be more skilled and, therefore, were burdened with more laborious tasks or tasks that did not correspond to them, in addition to dealing with colleagues who did not generate confidence when realising their tasks, which was why the feeling of insecurity was present in the Spanish migrant nurses´ discourse on certain occasions.

Pattern C: Cultural shock

Study pattern C allowed us to appreciate all the effects of culture shock on the perception and relationship with the work environment of Spanish migrant nurses. From a personal point of view, it represented a challenge to adapt to an environment culturally so different from the one they came from, even going so far as to reconsider their plans for the future after experiencing nursing in Norway. From a labour point of view, migrant nurses´ discourses showed moments of harmful discrimination by patients and colleagues and moments of positive discrimination that, in the end, turned against them for their nursing

tasks. The most used discursive strategies were those of exemplification, comparison and polarisation.

Major theme 6: Cultural issues in the migration experience (116) – (136)

Numerous exemplifications enriched the discourse of Spanish migrant nurses regarding their personal experiences in their labour journey through Norway. The situational and personal context marked these experiences, and the migrant nurses highlighted the positive and negative aspects of living in Norway through comparative strategies. Their dis-courses were full of references to Spain. At the same time, they highlighted the difficulty of adapting to a climate, environment and culture so different from that of their homeland. Regarding the personal perception of working conditions in Norway, we considered it interesting to highlight the speech act (119), in which the resource of syntax parallelism is used ("I don't want to be called to work for two months, my contract runs out; they call me for another month, and my contract runs out") to polarise the perceived job insecurity in Spain compared to Norway. Prejudices also appeared in (122), in which a migrant nurse assumed that her assumption about the Norwegian people was wrong, which was less favourable than what she experienced.

Regarding the cultural experience of Spanish migrant nurses in their jobs, an adverse circumstance linked to perceived moments of racism abounded in their discourses. In this sense, the lexicon used was quite explicit and contained a tremendous illocutionary force ("I felt attacked", "they have had some racist problems", "because you are a foreigner", "I have felt somewhat discriminated against") which conveyed a solid dis-criminatory feeling in the workplace,

something that made them adopt an unbalanced relationship of power with their Norwegian peers. The work role of the migrant nurses was the same as that of their Norwegian counterparts. Still, due to occasional discriminatory circumstances, they were viewed as somehow inferior by their peers and by the Norwegian older patients themselves, as evidenced by speech acts (123), (124), (130)-(132) and (134). On the other hand, the discourse of migrant nurses also reflected culturally different perceptions regarding colleagues and patients, which disoriented them a bit, as reflected in the speech act (125) or (135). Returning to the situations of discrimination, it was noticeable that they suffered not only moments of harmful discrimination but also positive discrimination. In other words, and in line with (126), (128) and (133), the Spanish migrant nurses were aware, through generalisations, that their work and training were reasonably well regarded in Norwegian nursing. However, concerning this positive discrimination, through exemplification strategies and their use of lexicon ("I may have felt a little forced to do something in some situations"), we could interpret in their speech acts that it was something that did not seem entirely appropriate to the Spanish migrant nurses since they were made to take care of specific tasks that did not belong to them or that they were not previously consulted.

DISCUSSION

The situations of active listening, decision making and participation in care were the epicentre of the imbalance in power relations between older patients and home nurses. The importance of reconciling active listening, decision-making and participation in older adults has already been highlighted by Koskenniemi et al. [55], who defined acceptance, active listening, commitment, and warmth as pillars of care based on respect [56]. However, our results highlighted barriers to the appearance of active listening situations due to introverted personal characteristics from the older patients´ side or less empathic responses from the home nurses´ side. Nevertheless, this contrasted with the discourse of the Spanish mi-grant nurses, who claimed to make great efforts to dedicate time to therapeutic communication since they considered it essential to listen to older people, something shared by various studies that underline the importance of inclining to listen to older patients and take their preferences seriously [57,58]. On the other hand, in the discourse of the migrant nurses, there was a component of impotence due to the lack of time that would allow them to develop easier active listening towards all older patients, which was consistent with Anshasi et al. [59].

Regarding shared decision-making situations, the results of this study revealed a bleak picture due to the non-existence of these in the case of Norwegian older patients. These results are consistent with a recent study conducted by Keij et al. [60]. With a very similar sample size, older patients found it more challenging to participate in shared decision-making because they were victims of a paternalistic decision-making style that prevented them from absorbing information and expressing themselves. However, according to the migrant nurses' discourse, these situations were influenced by the attitude of the older

adults. This ap-parent contradiction makes sense when related to other studies that consider this process a phenomenon full of uncertainty that requires a dialogue attitude on the part of older patients and health personnel [61,62]. There was more uniformity in the discourses regarding active participation since most of the older patients stated that they participated in tasks related to their care. The migrant nurses extolled the vital role that introducing them had for older patients' health, which agrees with other studies that understand the participation process as an act that requires equality in power relations and communicative understanding [63,64].

Regarding the consequences of this imbalance of power relations, the discourse of the Norwegian older patients and the Spanish migrant nurses converged on the adverse effects of a deficient care organisation and the professionals' lack of time. In addition, older people and migrant nurses showed signs of mistrust towards the work environment due to their perceptions about the sometimes-inadequate training of some colleagues. All this related to the organisation of care, lack of time, and distrust agrees with the study carried out by Bravell et al. [65] in a Nordic work environment which is culturally transferable to the present study.

Regarding the migratory experience, this study has emphasised the effect of culture shock that Spanish migrant nurses have experienced in the care they provide. The results of this study show, broadly, culturally competent migrant nurses regarding Campinha-Bacote´s Model of Care of Cultural Competence in the Delivery of Healthcare Services [27,66]. Spanish migrant nurses were aware of the images they carried about the Norwegian people, something they identified in their migrant experience as nurses and discussed this experience with the researcher, which is consistent with the concept of cultural awareness [67]. In

addition, through their speech acts, we could ascertain that Spanish migrant nurses could assess the Norwegian older patients in their cultural context, even adapting at specific times to individual wishes or needs. This meets the cultural skill concept. As for the concept of cultural encounters, the mi-grant nurses fulfilled it satisfactorily since not only did they not shy away from face-to-face meetings with older Norwegian patients despite specific language restrictions, but the nurses also sought out these encounters to establish communication and get to know their patients. The last concept of cultural desire represents the cornerstone of cultural competence since it feeds energy and motivation to the health professional to become culturally competent [68]. This was something we discovered throughout the discourses of the Spanish migrant nurses, as a result of this study, despite sometimes suffering work overload that prevented them from carrying out their tasks satisfactorily.

The labour discrimination perceived through the discourses of the migrant nurses revealed that the lack of mastery of the Norwegian language acted as a limiting element in the relationship with other colleagues or patients, who even went so far as to demand the presence of Norwegian nurses, something that agreed with studies exploring the experiences of other migrant nurses in Norway [69,70]. However, despite classifying these as racist experiences, the Spanish migrant nurses declared that they also perceived positive discrimination at the same time as they were considered skilled and highly valued, consistent with the work by Munkejord [71]. On the other hand, better labour and economic conditions were one of the reasons why migrant nurses leapt abroad to work as nurses. This made them reluctant to return to their homeland in the short term following their speech acts, thus agreeing with other studies about migrant nurses in Norway [69,72]. At the same time, these nursing migration results in the

Norwegian context are also consistent in non-European settings, such as the United States as a country suffering from a nurse shortage [73]. This deficiency is partially resolved by welcoming nurses of foreign origins, such as Philipines, whose reasons for taking the step to undertake their profession outside their native country are partly economic and labour conditions, as our results also reflect with our study participants [74].

The use of specific discursive strategies and arguments made the Norwegian older patients and the migrant Spanish nurses project different social representations. Norwegian older patients generally adopted a double image, as a victim, on the one hand, for not feeling involved in their care at times and for not being treated as they deserved by home nurses; of agency, on the other hand, through a discourse that sometimes made explicit the desire to change things. Spanish migrant nurses adopted, for their part, an image committed to the profession and the care they professed, but at the same time, said care was influenced by negative experiences at times, from a cultural and organisational point of view, in addition to pointing out also to older people sometimes as responsible for frustrated moments of active listening, decision making and participation. This coincides with Tajfel's theory of social identity [49,75], which understood the attitude of the members of different social groups as a reflection of the identity of belonging to each group, whose purpose is to positively visualise their actions above that of the others, on which negative aspects stand out [51].

Strengths and limitations of the study

The main strength of this study lies in incorporating the sociocritical perspective of DS in the context of the migrant experience of Spanish nurses. The CDA has already been shown to be helpful in nursing research, as proposed by Powers [47]. This study also makes visible a reality that is increasingly present in

our days, in which the current demands in the healthcare system worldwide push many nurses to decide to emigrate for leaving socioeconomic conditions that do not fit with the training and work capacity that they acquired in their countries of origin. On the other hand, we have invested a great effort in describing in detail the methodological framework of this study, in addition to adequately organising the results obtained, providing detailed information on the preparation of the research and following rigour and quality criteria following the trans-cultural perspective that we have adopted.

We decided not to have older patients who suffered from cognitive impairment or were terminally ill. This could be considered a limitation, but we understood these subgroups of older patients as another different patient profile requiring particular care, which somehow influences the discourse. On the other hand, the short number of Spanish migrant nurses participating in this research can be considered limiting. However, it was already difficult to find Spanish migrant nurses who met the agreed selection criteria. On the other hand, we refer to Malterud et al. [76], who state that in qualitative research, a sample rich in information comes from a low number of participants who confer it. Another area for improvement of this study is that it was not possible to triangulate the transcribed material with the participants after the data collection, despite performing an intra-interview triangulation.

Relevance to clinical practice and healthcare policies

The present study has explored power relations between Norwegian older patients and Spanish migrant nurses. The negative effect of a specific imbalance on situations of active listening to preferences and shared decision-making reveals the urgent need to develop measures and interventions that promote a

horizontal relationship, in terms of collaboration, between nurses who provide services at home and older patients who receive it. It is vital to implement alternative models of response to the health problems of older adults in the community so that it is possible to include them in the decision-making processes to provide quality nursing care [77]. On the other hand, a detrimental context in which home nurses find themselves has been revealed, which causes an overload of work, deficiencies in the care organisation and mistrust in the work environment, the effects of which are well-known and endorsed by the scientific literature, harming the quality of care. For this reason, it becomes urgent to listen to and attend to the needs of home nurses and also to attend to the power imbalance between home nursing staff and home care management organisations. Finally, we want to highlight the importance of caring for migrant nurses, who deserve to be considered given their culturally unique condition, so that they feel inserted and move away from discriminatory experiences to confer added value to their transcultural care so that special attention from health systems and agencies is necessary.

CONCLUSIONS

This study has revealed an imbalance in power relations between Norwegian older patients and Spanish migrant nurses in-home nursing. Active listening situations were influenced by elements such as limiting personal qualities of Norwegian older people and less empathic responses by home nurses in general, based on the discourse of older patients. The discourses of the Spanish migrant nurses coincided with the older adults in the personal aspect of these patients as a communicative barrier. Regarding decision-making situations, the discourse of the older people made it clear that at no time had they enjoyed the opportunity to decide, some older people being prone to have an attitude of agency concerning the process, and others a passive attitude. The discourse of the migrant nurses made it clear that they were aware of the importance of deciding together, but sometimes they seemed not to carry it out. Regarding participation in care, the discourse of the older patients and the migrant nurses were more in unison, highlighting a participative intention in most older adults and a respect for engaging them from the home nurses. However, the true origin of this imbalance is mainly affected by the institutions that organise home care. The work context, the lack of organisation of visiting hours with the older patients, the lack of time, and the distrust towards some members of the nursing team, were an indirect consequence of a silent power relationship between the care institution and migrant nurses, the latter subjected to the former. Finally, the culture shock had a significant positive and negative weight on how Spanish migrant nurses related to their environment, thus shaping their perception and way of providing nursing care. Regarding the latter, the speech acts of Spanish migrant nurses have revealed that they are culturally competent professionals.

The social representations emitted by the Norwegian older patients were victims for being the last link in power relations; on the other hand, patients with dignity and assumption about what they want and need. The social representations of Spanish migrant nurses were those of a professional group committed to their work, critical of specific situations of social injustice and influenced by cultural elements in their migratory experience.

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Tables, figures and supplementary material

Table S1. Report using the COREQ checklist for reporting qualitative research.

Domain 1: Research team and reflexivity	Description
Personal Characteristics	
1. Interviewer/facilitator Which author/s conducted the interview or focus group?	PMA conducted all the interviews.
2. Credentials What were the researcher's credentials?	PMA was a PhD student and MSc in Health sciences research. MRR, PVP, and SLQ were PhDs.
3. Occupation What was their occupation at the time of the study?	PMA was working as a Research Fellow at the University of Córdoba (UCO). MRR and SLQ were working as full professors at UCO. PVP was working as an assistant professor at UCO.
4. Gender Was the researcher male or female	PMA, MRR, PVP, and SLQ are male.
5. Experience and training What experience or training did the researcher have?	PMA had experience in qualitative research from previous works. He received a Master's degree in Health sciences research from the University of Jaén (UJA), Spain. In addition, he underwent formal PhD education in qualitative research and gave teaching lectures during his fellowship.
Relationship with participants	

6. Relationship established Was a relationship established prior to study commencement?	There was no previous relationship with any interviewee since the interviewer of the research team knew them at the time of data collection. PMA had a prior relationship with the rest of the group: MRR and SLQ were their doctoral thesis supervisors; PVP was a colleague from the department.
7. Participant knowledge of the interviewer What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	PMA informed the participants that the research project belonged to a thesis project of PMA. The leading researcher told Norwegian older patients and Spanish migrant nurses his purpose with the study. When the participants asked questions about the project, they were answered by both researchers.
8. Interviewer characteristics What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	The principal interest of PMA in the topic was based on his desire to focus its thesis project and future research on situations of social injustice, imbalance of power, and possible discrimination in care contexts in the primary care setting.
Domain 2: study design	
Theoretical framework	
9. Methodological orientation and Theory What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	The research paradigm for this study was hermeneutic with a critical perspective. Using an interpretative methodology, researchers could dive into the reality of other individuals. Using a critical discourse analysis (CDA) perspective, the researchers had a reflective approach to possible social injustice and discrimination situations to locate care failures and highlight areas for improvement in the care from health services. Having a transcultural perspective, the researchers could have an insight into how the cultural shock affected the care experience of Spanish migrant nurses;

	besides, they were culturally competent professionals. This study analyses the power relationships between Norwegian older patients living alone and Spanish migrant nurses attending them at home. We followed Crist & Tanner´s hermeneutical considerations, alongside linguistic analysis regarding CDA, to understand participants´ interpretations of the phenomena studied.
Participant selection	
10. Sampling How were participants selected? e.g. purposive, convenience, consecutive, snowball	The article explained the sampling method, and all approached Norwegian older patients, and Spanish migrant nurses agreed to participate.
11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email	All Norwegian older patients were approached face-to-face with help from nurse care managers and referral nurses who reached them. In the case of Spanish migrant nurses, snowball sampling was employed through email.
12. Sample size How many participants were in the study	There were fifteen semi-structured interviews; eleven were with older Norwegian patients, and four were with Spanish migrant nurses.
13. Non-participation	None of the participants who were asked to participate refused to be part of the study or withdrew from it at any time.

How many people refused to participate or dropped out? Reasons?	
Setting	
14. Setting of data collection Where was the data collected? e.g. home, clinic, workplace	The interviews took place at the participant's preferred location. This location was their home for Norwegian older patients. Zoom platform via videoconference with Spanish migrant nurses.
15. Presence of non-participants Was anyone else present besides the participants and researchers?	Only the participant and the researcher were present in all the interviews.
16. Description of sample What are the important characteristics of the sample? e.g. demographic data, date	All participants´ characteristics are described in Tables 2 and 3.
Data collection	
17. Interview guide Were questions, prompts, guides provided by the authors? Was it pilot tested?	The authors provided the interview scripts as supplementary files to this article. The list of topics was adjusted to each situation´s uniqueness throughout the research interview phase.
18. Repeat interviews	Repeated interviews with the participants were not conducted. As for the Norwegian older patients, this was due to their multimorbidity and because

Were repeat interviews carried out? If yes, how many	many reported their state of fatigue concerning the realisation of interviews. As for the Spanish migrant nurses, this was due to their difficulties in joining again.
19. Audio/visual recording Did the research use audio or visual recording to collect the data?	All interviews were audio recorded with the participant's verbal and written consent. The recordings were stored on a PMA computer because he was responsible for data analysis. Only he had access to this data.
20. Field notes Were field notes made during and/or after the interview or focus group?	The audio recording was accompanied by a hermeneutical diary which included observations and impressions that were not recorded, such as the non-verbal communication of the participant. It contained reflections through a self-hermeneutic process during the study as well. Field notes were used in the analysis of the results afterwards.
21. Duration What was the duration of the interviews or focus group?	The time of the semi-structured interviews was approximately 50 minutes on average.
22. Data saturation Was data saturation discussed?	Data saturation was discussed with the research team.
23. Transcripts returned	Due to various reasons (such as the limitations in the reading of most of the older patients due to medical or literacy issues; a state of exhaustion after the

Were transcripts returned to participants for comment and/or correction?	completion of the interviews), the transcripts were not returned for comments or feedback. The transcriptions were not returned to the migrant nurses because of time unavailability.
Domain 3: analysis and findings	
Data analysis	
24. Number of data coders How many data coders coded the data?	PMA performed the critical discourse analysis. MRR supervised the research alongside SLQ.
25. Description of the coding tree Did authors provide a description of the coding tree?	No coding tree was used. The themes were derived from the data, following Crist & Tanner´s hermeneutical considerations alongside a linguistic analysis in the data analysis phase. The authors provided narrative and visual development of this process in the article.
26. Derivation of themes Were themes identified in advance or derived from the data	The themes were derived from the data and were discussed and agreed on by all the authors.

27. Software What software, if applicable, was used to manage the data?	SimpleMind Pro was the software tool for managing the data visually.
28. Participant checking Did participants provide feedback on the findings?	Due to several reasons, as explained at number 23, there was no feedback from the participants on our findings after the interviews. During the interviews, the interviewers repeated and summarised the participants´ answers to ask for clarification and confirmation of the researcher's interpretation of the answers. At the end of the interview, the researcher summarised the content to ensure the researcher understood the main content correctly. At the end of the interview, the researcher also asked the older patients and migrant nurses a final question about possible comments they wished to make regarding what had been said and potential topics not raised through the conversation but that they wanted to make explicit.
Reporting	
29. Quotations presented	The results section is illustrated with speech acts as quotes from the participants. Each quote is identified with a participant number.

Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
30. Data and findings consistent Was there consistency between the data presented and the findings?	According to our assumption, the data presented in the study and the results that emerge from them are consistent.
31. Clarity of major themes Were major themes clearly presented in the findings?	The major themes are present in the results section of our article. Each theme is assigned a different heading.
32. Clarity of minor themes Is there a description of diverse cases or discussion of minor themes?	The minor subthemes are described along with the major themes, accompanied by specific quotes for each one.

Table S2. Reflexive questions adapted from Joseph et al. [50].

Reflexive questions	Researcher responses
Domain 1: Sensitivity	
What are the participants' and the community's experience of qualitative research?	Participants had no previous experience in taking part in qualitative studies.
How does the gender and age of participants define the method of communication?	The interviewer was a man of 28 years old. Concerning Norwegian patients, all were women with a mean age of 83. Concerning Spanish migrant nurses, all were women with a mean age of 26. The communication method was also influenced by the language used: the native language in the case of interviews with migrant nurses and the language learned in the case of older patients. This, added to the age difference concerning older patients, determined the communication method more directly and compared to migrant nurses, with whom the interviewer felt more comfortable and with a more accessible language from the point of generational and idiomatic view.
How intrusive are the research topic and research questions?	The interview questions were direct about: whether they were told to choose something, if they felt heard or if they participated in something, for older patients; if they gave older patients something to choose, if they listened to older patients, if they encouraged to participate, and how the experience in Norway affected them in their personal/ professional plane, in the case

	of migrant nurses. However, the research team took care of the script so that the questions were polite.
Is the research topic related to a taboo subject or issues normally only discussed within the household?	No
Are there areas in the research community that are restricted or inaccessible to researchers due to their socio-demographic characteristics?	No
What is the research community's perception of the research topic?	The study of interactions in care between nurses and patients from different cultures is perceived as necessary and current by the scientific literature, as well as being key in an increasingly globalised world where health needs must be urgently met.
Where are the points of potential sensitivity?	The points of potential sensitivity were the explicit examples that patients and nurses used based on their vital experiences about situations where quality care was not being carried out concerning the study phenomena. In other moments they identified a manifest power imbalance with negative consequences in the nurse-patient relationship.
Does the researcher have the set of skills needed to show cultural sensitivity?	The leading researcher demonstrated cultural sensitivity skills because at no time did the patients or nurses refuse to answer any questions or give examples. The leading researcher knew the Norwegian language and had worked as a home nurse in Norway for two years. He knew the work and cultural context he found

	himself in during the interviews with Norwegian older people — the same with the Spanish migrant nurses.
What are the participants' expectations from the researcher and the study?	The Norwegian older patients expected the research to make their situation visible and to be heard. The Spanish migrant nurses expected the study to share their experiences and make their work and personal context visible in a different culture.
Domain 2: Vulnerability	
Are participants able to make an informed decision on whether to consent to take part?	Yes
What is the protocol for community entry; does it require permission from a gatekeeper to approach potential participants?	In the case of Spanish migrant nurses, it was not necessary. In the case of Norwegian older patients, it was required to approach the supervising nurses first to approach potential participants.
What is appropriate for participant reimbursement?	There were no costs that were reimbursable in this study.
Are participants at risk of coercion or exploitation?	No
Which characteristics of the participants expose them to risk of exploitation?	In the case of patients, having advanced age and living alone. In the case of migrant nurses, their situation of cultural vulnerability.
Does the researcher's identity pose or worsen physical and emotional risk?	No

What makes researching these social groups different to researching others?	This research precisely bases its importance on the relationship between two opposing social groups, finding differences in age, work context, and cultural context. Studying these social groups and their interaction makes a difference in the conception of care situations in which power relations in a different cultural environment are not considered.
How might participants' vulnerabilities prevent researchers from accessing research sites and undertaking their research?	In the case of Norwegian older patients, living alone and conducting the interviews in their homes could be limiting. However, the leading researcher gave the choice of where the interview would occur at all times to alleviate this potential consequence. All the older adults could decide on the interview place, date and time slot. In the case of Spanish migrant nurses, special consideration was also given to their low availability due to labour issues, so we perfectly adapted to their needs.
How can the research team ensure that their research processes will not further marginalize the vulnerable?	The research team implemented good practices to engage in culturally sensitive interview practices that could be seen in the article Data collection section.
Is the researcher also at risk?	No
What safety measures need to be taken before embarking on the study for the researcher and participants?	We carry out measures such as informing the participants in detail about the study and objectives and ensuring the confidentiality of the data obtained. We also request informed consent by signature and bioethical permission from the

	respective competent institutions in Spain and Norway. We received approval for our study before the data collection phase.
Domain 3: Cultural identity	
Is the researcher aware of their own cultural beliefs and how they might influence the interpretation of the participants' responses?	Yes. The leading researcher assumed sociocultural elements that shaped the meetings and reflected them in a hermeneutical diary.
Is the researcher knowledgeable about how culture and religion can affect participants' participation in the research?	Yes [see response above].
Is the researcher knowledgeable about how cultural norms may influence communication, for example, decision making roles (should be mutual between researcher and participant), eye contact, interpersonal space, use of gestures, asking and responding to questions, and use of humor?	Yes. The leading researcher was knowledgeable about proxemics, kinesics, body language, and cultural norms of the encounters.
What facets of the researcher's and participants' identities are most significant in the ongoing research?	The most determining facets of identity in this study were the self-concept of the older patient, in the case of the Norwegian older adults, and the self-concept of the outsider, in the case of the Spanish migrant nurses. In the case of the researcher who carried out the interviews and the critical discourse analysis, the outsider researcher-nurse culturally adapted to the context of the present study.
How do the participants relate to the researcher's identity?	In the case of older Norwegian patients, there was an empathic listening relationship by recognising the researcher as a

	professional interested in their situation and cultural context. In the case of migrant Spanish nurses, a fluid and empathetic relationship was due to sharing professional, cultural and personal grounding with the researcher.
Are there enablers or helpers in the research setting and, if so, how can the researchers identify them?	No
Does the researcher's identity make this research a more sensitive topic, leading to a discussion that could upset the participants?	No
How does the researcher's identity influence the cultural expectation of participants and the host community?	The researcher's culturally distinct identity concerning Norwegian older people probably defined their expectations. The older patients emphasised the situations experienced to the researcher so that he was fully aware of what it was generating in the discourses. The host community and the participants represented a cultural challenge for the researcher.
Does the research team have the necessary knowledge, skills, and tools for reflexivity?	Yes. Taking the Campinha-Bacote model as a reference, self-hermeneutics was exercised as a reflective introspection.

Does the researcher have the skill to adapt their communication style to effectively interact with people who communicate in ways that are different from their own?	Yes. The leading researcher had previously dealt with Norwegian older people during his practice as a home nurse in Norway, so he cultivated his communication skills in that cultural context to provide care and communicate effectively.
Does the researcher have the skill to consistently act in ways that demonstrate respect for the culture and beliefs of others?	Yes. Transcultural nursing is based on a respect for others´ cultures and identities that the leading researcher cultivated while working as a nurse in Norway.
How can the researcher gain acceptance within the community and from the participants?	We gain acceptance through a gradual approach to the participants and by carrying out full transparency and accessibility regarding the study and the ethical issues associated with it. On the other hand, we always proposed maintaining a relationship of warmth and empathy towards the beliefs and culture of the participants.
Do the researchers have adequate information from interpreters and community members about the study community including appropriate social routines/practices?	The leading researcher was assisted by Norwegian research nurses who were fully aware of the Norwegian nursing care context, codes and culture.
What are the researcher's biases and assumptions about the community?	Preconceived ideas about the community of older patients living alone and receiving nursing home services were that they

	probably suffered from loneliness and some of their unmet needs.

Table S3. Major themes, minor themes and informative excerpts of CDA from the research corpus.

Major theme 1: Interferences in communication	
Minor theme 1: Difficulty with expressing preferences	**Minor theme 2: Clear theory, unclear practice**
Norwegian older patients	**Spanish migrant nurses**
(65) Sometimes, yes. But not much. But they can have a lot to do, and it´s not always the worst with me. There may be someone worse [shy laugh] (no. 1). **(66)** If I need something, I ask for it. It's not hard to talk to them, either. But you know that some want to, and some don't. That can be seen (no. 1). **(67)** Maybe they could talk a little more with me... [laughs] (no. 2). **(68)** I don't ask for anything; I count on them to do what they must do (no. 3). **(69)** Not all who come are the same, some talk a little with me, and others do what they have to do (no. 4). **(70)** If I'm sunk, yes, if I'm in the process of sinking, I don't usually comment on it (no. 7). **(71)** I'm not a person who talks too much. I prefer to keep to myself. But I arrange it alone. I arrange it (no. 7). **(72)** I've never been used to that; I've always been to figure out life for myself. So it's hard... (no. 8). **(73)** It's easier to tell them depending on who, but I get anxious when I see certain things happen. Everyone has the right to express themselves and give their opinion. But I have difficulties expressing myself, yes (no. 8). **(74)** Once, I got up and had to lie down again because I was dizzy. And I was in the hospital, and I had a drop in blood pressure. And the nurses knew that. But they told me, "Bah, that passes immediately" (no. 8).	**(78)** Asking them what did they think of the service? I don't know, no, no... (no. 12). **(79)** To me, they tell complaints, personally [laughs]. It's like that when you go their home, people complain, and the good things are valued many times less than the bad ones, I also tell you (no. 12). **(80)** I think that, after all, when you go to a house and have an estimated time, you have to say, "I'm here for this; do you need anything else?" But of course, they will always need something more (no. 12). **(81)** I think that if you are open, it will cost you less; if you are shyer, it will cost you more to communicate. If you think about it and are empathic: if a person comes to your house because you can no longer do things as you could before... It is challenging to communicate. Many things are not said, I think (no. 12). **(82)** Despite feeling limited by the Norwegian language, I have had the opportunity to sit down and listen to a patient for half an hour about what they wants, what they doesn´t like, what they needs, in short... How can I make them feel comfortable? That´s not so easy in Spain (no. 13). **(83)** It is essential to listen to patients; for example, there are those with depression who sit on the sofa and say they are not sociable. They need to be heard (no. 13).

(75) If it [what she asks] ends up being done? No. I have told them several times to come a little earlier, but there must be something they don't like, so I feel a bit guilty [laughs] (no. 8). **(76)** It happens that I usually say what I think, and before I even signed the papers that said I would receive specific help, they have not followed it (no. 9). **(77)** I could only say that the afternoons get very long in winter, especially when you feel alone (no. 10).	**(84)** I think it depends on the personality of each one. Because there are people who don´t want to adapt and do everything as they wish (no. 13). **(85)** I guess it depends on what it is. I had a case of an older person who did not want to go to a hospital, and we could not give her optimal care at home. Her daughter also wanted to admit her to a hospital. In the end, the older patient had bilateral pneumonia. And she ended up dying there. So I don't know to what extent the patient's opinion should be respected or when their preferences should be followed. In those cases, I think about care. If it is unrealistic to follow her wishes, and I cannot guarantee care, they cannot be in an unsafe environment (no. 14). **(86)** If they have to complain, they do it a lot. They also tell you what they like and don't like (no. 15).
Major theme 2: Asymmetry in decision-making	
Minor theme 3: Not deciding at all	**Minor theme 4: Real situations or mirages?**
Norwegian older patients	**Spanish migrant nurses**
(87) Those who work there [referring to the nursing staff who work in the office and organise the visits] decide. And it seems that it's all right, most of the time (no. 1). **(88)** No. I can't remember any [actual situation of decision-making] (no. 1). **(89)** Yeah, no... [pause] [laughs] I don't know [laughs]. I haven't had any situations yet, but you never know (no. 2). **(90)** They are the ones who carry all that. It's fine the way it is (no. 3). **(91)** I have nothing to tell... They do what they do, full stop (no. 3).	**(98)** In the case of certain conflictive patients, you have to stand up. For example, if they want certain things done their way (no. 12). **(99)** As simple as asking them, "hey, what do you want me to make you for breakfast?" Well, some colleagues do not. That seems... They´re losing their independence; at least, you have to ask them (no. 12). **(100)** Sometimes, we are a bit "the bosses" who decide what is done or is not done. If, for example, I see that something beneficial can be done and is suitable for the patient, I try to do that (no. 13).

(92) No, I only receive visits and medicines. I have not had any possibility about what you say [to be able to decide on something] (no. 4). **(93)** [Pause] No, nothing special (no. 6). **(94)** Decide? No, I couldn't [Pause]. For example, I don't really like taking a shower in the morning. I do not do it. That's why I can smell a little sweat from time to time. That's why they go after me sometimes. “You have to shower” [he repeats it several times]. And then I'm… [he gestures of being fed up, holding his head] (no. 7). **(95)** I could gladly think about it. Decide here and there a little like today; I feel strongly about that or not (no. 8). **(96)** No, I don't choose anything; here comes the one that had to come… (no. 9) **(97)** No… I don't see that there have been any such situations, really (no. 11).	**(101)** Certain patients sometimes say they don´t want to take their medication today. So, I don't try to force them but to convince them why they should take medicine and why it is good for them. But the decision always comes from the patients (no. 13). **(102)** As for the treatments, patients usually do what the doctor tells them, regardless of whether it is positive for older people. They often don´t make a clear decision due to ignorance unless it is explained to them. Other times they do not intervene because of family issues when the family dismisses the patients as older, so they decide for them. That is something that I find sad (no. 14). **(103)** Here in Norway, the opinion of older patients is taken into account very much. I even consider that sometimes too much [laughs] because once I had a patient with dementia who was not in all his faculties and made decisions that affected the assistance and quality of health of that person, being validated (no. 15).
Major theme 3: Heterogeneous participation and its influential elements	
Minor theme 5: Small and irregular performances	**Minor theme 6: A well-oriented participation is vital**
Norwegian older patients	**Spanish migrant nurses**
(104) No. Because I prefer to rest a bit (no. 3). **(105)** Well, I usually say when it´s a bit left until the nebulisers run out. I have also washed off the nebuliser mask several times for the next time. No one has asked me to do it (no. 4). **(106)** There have been times when it has not been necessary to irrigate, and I have said it before (no. 5). **(107)** I also usually leave the material prepared for when they come to irrigate my urinary catheter (no. 5). **(108)** No… I don't know what to answer [laughs] (no. 6).	**(114)** I think that some older people do participate. As far as possible, when I go to a house, I try to get them to do what they can because we are here to help (no. 12). **(115)** If they can do something, let them do it. After all, it is their daily training. Because if not, they end up deteriorating more. They stop being people (no. 12). **(116)** In nursing matters, such as intravenous treatments, these are things that you are the one to do. But for example, if we are talking about personal hygiene, something as

(109) Let's say it's Saturday or Sunday, so I'm not here around 8-9 a.m., and then I can stay in bed until 9:30 or 10 a.m. Then I let them know when I get up so they can come (no. 7). **(110)** [Participation] means absolutely everything. Because you don't become something like... You should avoid being behind them all the time so you can do things too (no. 8). **(111)** Not because I'm thinking all the time... I think about this, I think about the other... I've been alone for a long time... So no... I sleep poorly for a couple of hours, and then I come and sit on the couch (no. 9). **(112)** I think I could do more than I do. They don't let me get up and cut bread; they don't let me mop the floor... And those are the kinds of things I'd like to do... Uh... because I'm still a person... I can knit a little... like this. And it is partly the nurses who decide. They don't come in much more than to give me insulin... (no. 11). **(113)** I would like to try a little more to do more things alone (no. 11).	simple as saying, "I'll go with you to the bathroom, and you clean up there, and I'll help you below." (no. 12). **(117)** I think that the nurse is the one who guides the older patients when we go to their homes; if they are not told what they can do, time is saved, but you don't let them participate. But that is not fair, even if it takes longer. The problem is time (no. 12). **(118)** We always try to involve the patients as much as possible. Our routine is to explain to the patient what needs to be done and ask their opinion whenever they are oriented; if not, we ask the family's opinion (no. 13). **(119)** Participation is paramount as long as they are receptive. That's why it's essential to ask (no. 13). **(120)** I have realised that, here in Norway, no matter how older people are, they want to do everything they can. So yes, here, autonomy is encouraged a lot. Is it always fulfilled? No, but you try (no. 14). **(121)** In Norway, older patients are left in the hands of professionals when they really could have a more significant role in their care (no. 15). **(122)** With those most cooperative, I have tried to get older patients to do things too. Others don't because there's no way for them to collaborate, and you get to know them (no. 15).
Major theme 4: Lack of organisation, time and staff	
Minor theme 7: "Subservient to when they come"	**Minor theme 8: Extremely short on time and understaffed**
Norwegian older patients	**Norwegian older patients**

(123) They usually tell me when they are coming. Some arrange for them to come earlier, but sometimes they come a little late, and I call to see if they are coming. But mostly, they come (no. 1).

(124) There was one time they forgot about me, and I was pretty surprised. And it's not normal. They had just forgotten about me. It was an afternoon, yes. And then they worried me (no. 1).

(125) They come directly. And if I'm not at home, they put the medicines inside the house (no. 2).

(126) They come when it suits them... It works for me, too (no. 3).

(127) They come when it is best for them to arrive. It's tough. After all, I want to have an apparent time reference because otherwise, I can't go out, and I have to sit and wait for them to come. Otherwise, I could go out between hours and be prepared if I knew when they were coming. And that's important because I was used to going out whenever I wanted, but for a while now, I've been sitting at home a lot, and it doesn't seem right to me (no. 4).

(128) I'm subservient to when they come (no. 4).

(129) They come when they do best according to the patient list (no. 7).

(130) They usually come too late (no. 7).

(131) No, no, they come when they want (no. 8).

(132) They don't always come when they should, I wait here [at home], and there are times when they don't come, and I have to call them (no. 9).

(133) When it was 9 a.m., for example, they had yet to come, and I was going to have breakfast, and I had to wait until 10 a.m. (no. 11).

(134) They have very little time, but some are skilful at making time. Because they go to so many places and so many medicines for us... (no. 1).

(135) They may be swamped (no. 3).

(136) Yes, there have been times when those who have come had three patients simultaneously. That is not possible. They had two in an outlying area and one near here. And can they come to me at 8 a.m.? It's not just about me, but also about them (no. 4).

(137) They are swamped! Some stand up and don't sit down to give me the medicines, and I get nervous; you could say because I understand they are very busy. And there have been times when I was in much pain, and they didn't even notice [she laughs resignedly] (no. 4).

(138) No, think about time and patients. One, two, three, four, five, six, seven... And I am one more number among them (no. 7).

(139) They will have a lot to do, I suppose? Because they have come several times at 9:30 in the morning to give me the medicines, and it is a bit late, I think (no. 8).

(140) There are few staff, few people. Yes, because there have been several who have left, and two young people come to cover them, and they don't always come knowing how things are and also, yes, it is not so easy to go and adapt so quickly (no. 9).

(141) Don't know. Do they forget... they don't have time...? That's what they usually answer. The reason will be that they don't have the capacity, they don't have time... (no. 9).

(142) Many others are more important than me because I only have compression stockings (no. 9).

	(143) They don't have time, so you can't always count on them: lots to do, few people (no. 10). **(144)** They have had difficulties because they need more staff. So...it's been tricky with the times they've come here, but okay (no. 11). **(145)** Hire more people and pay them a better salary. That's... that's my suggestion. Because many of us are dependent, but... that's the way things are. They're very few. And when someone gets sick, it's almost a crisis (no. 11).
Minor theme 9: "We try... But generally, it´s impossible"	**Minor theme 10: Extremely short on time? and understaffed**
Spanish migrant nurses	**Spanish migrant nurses**
(146) [Are the visits adapted to the patients' routine?] We try; that's why there are no fixed visits every single day. It is asked in advance what time slot it´s best and if they have something to do, as likely as possible (no. 12). **(147)** It is angrier when you go to a house, and the patient is not there. That's what the phone is for, to say you're not going to be there (no. 12). **(148)** We can adapt to the patients' wishes at some specific moment. But generally, it´s impossible to follow all the opinions or needs. Because at the organisational level, it´s not possible (no. 14). **(149)** We try to meet patients' preferences regarding hours. But then you must readjust because some still prefer a time slot, corresponding to another person needing it more (no. 15).	**(150)** We have very little time; it is pretty controlled. The time is short. Lack of staff makes us minimise visits (no. 12). **(151)** I think that more [time] will always be needed, but I believe I give them the time they need (no. 12). **(152)** Even tho I think that here [in Norway], we have more time than in Spain (no. 12). **(153)** Sometimes, even you have to say, "I'm pretty pressed for time." And that's not the best thing (no. 12). **(154)** I like treating patients and chatting with them while I do things. That's why I'm almost always late with my visit list [laughs] (no. 12). **(155)** Lack of personnel, and that affects the patient. They are less listened to, or things could be done better. But that happens here and everywhere (no. 12). **(156)** I have also worked in hospitals, and we don't have much time either (no. 13). **(157)** I think older patients get the needed time. [pause] In my workplace, I believe that staff who don't have enough time

	it´s because they don't want to organise their time better or their free time, to dedicate to an older person (no. 14).
Major theme 5: Consequences of lack of organisation, time and staff	
Minor theme 11: Unsatisfied wishes	**Minor theme 12: Mistrust in care situations**
Norwegian older patients	**Norwegian older patients**
(158) Maybe I could use a bit more help (no. 2). **(159)** I would always like to receive the same person. Or most of the time. Because continually explaining what they should do or how something should be done is tiring (no. 4). **(160)** I´d probably need more help in the winter than in the summer due to my phases of depression (no. 7). **(161)** It should be possible to agree on some time other than the scheduled visit because sometimes… [pause] I need someone who can "kick my a**". You know what I mean? And that they do not. Because I need… [gestures with hands] let's go! (no. 7). **(162)** Perhaps they could offer to manage things for me about the doctor, the dentist, uh… Like those things that are so difficult for me to do alone. I am also anxious because of the oxygen I put on (no. 8). **(163)** They could ideally use more time [laughs]. I have a shower daily; they only help me with a few things like changing my underwear and a compress because I don't wear a diaper, and uh… I could think about those kinds of little things (no. 8).	**(164)** Some don't know precisely what to do when they come, and that… And some fool around a bit… They don't turn the key when they leave (no. 4). **(165)** The issue of alarms doesn´t work well. I called an ambulance. And then, the ambulance should have contacted the nurses earlier to get into my house because they [the ambulance´s staff] were waiting outside until a nurse came to open the door for them. So… I wish there was a better routine because we, the dependents, must have confidence. But I'm not very confident (no. 8). **(166)** Some know more or can do more than others, so that [opportunity to choose who comes to her home] would be fine. But I'm not in that position; they go and do what they do (no. 9). **(167)** With my BiPAP, the device. Everyone knows you have to wash it sometimes. Yes, it has to be done, and sometimes they forget. Some are very good, but others… (no. 8). **(168)** They use the time they need but sometimes rush to finish (no. 9). **(169)** It depends a bit on who is coming. Perhaps there have been some who have gone very fast. But I understand because maybe there was someone they had to go somewhere else, so… (no. 11).
Minor theme 13: Imbalance in fulfilment of needs	**Minor theme 14: Insecurity and mistrust feeling in the work context**

Spanish migrant nurses	Spanish migrant nurses
(170) Some have even asked me to take the dog for a walk. And I said, "no, sorry, my job is to help you, not take your dog out." And I have done things that some have asked of me even if I didn't feel like it (no. 12). **(171)** You need more time to meet those extra requests. We complain about it (no. 12). **(172)** They always need psychological support in the sense of human warmth. I think most patients need it, but you can't give it to them because you have to go. That´s the problem of quality of care (no. 12). **(173)** I think patients do not receive what they need—for example, patients who have gone to the hospital due to an infection and are sent back home. And two days later, they had to be sent back to the hospital with sepsis because they were not given intravenous treatment (no. 14). **(174)** If there are cases in which tasks are evaded, I don't know if the reason is that they are older people or because nurses are saturated with work—or having certain patients with annoying personalities. In my case, there is an alcoholic patient who drinks a lot, and I don't feel like spending more time there than necessary (no. 14). **(175)** In the emotional sense, if we believe that in Spain, the older people feel lonely, in Norway, they are double. The family support is much less, and that you spend twenty minutes in the morning with them is not going to meet their need. Because then they are isolated seven days a week (no. 15). **(176)** There are situations where I think patients receive things they do not need. For example, an older person who lives alone at home has the right to receive something, and we go	**(177)** If I'm not used to a patient, I need three times as much time as that colleague who is (no. 12). **(178)** I have had a few instances where other colleagues have let me pass the buck. I think it's because they don't have the drive like us or feel insecure when making decisions. For example, I had a patient with significantly altered vital signs, and my colleagues did not see it as clear to notify the ambulance, so they asked me what to do (no. 15). **(179)** I feel somewhat insecure when I have to trust some colleagues because I don't see them as safe regarding nursing competencies. I have had colleagues with years of experience who didn´t know how to provide intravenous treatment (no. 15).

to their house to give them that. But it's more of a watchfulness that their children want, and maybe you're going to heat the food in the microwave, but it's something that person can do perfectly—a little for supervision or emotional support (no. 15).	
Major theme 6: Cultural issues in the migration experience	
Minor theme 15: Perceptions and context in the migration experience	
Spanish migrant nurses	
(180) Personally, I have adapted, but I don't think I will ever fully adapt. I love my family a lot. I have my partner and son here; we have bought a house and plan to stay for several years but want to return to Spain (no. 12). **(181)** [Regarding working conditions] I wouldn't want to go back [laughs]. That's the thing. For this reason, I am thinking about it, but my idea is to do a master's degree in education to go into teaching. Because I love nursing, but when you have a family… Schedules are essential with my son (no. 12). **(182)** I have earned much money because I have worked morning, afternoon and night shifts. Mainly my contract is for night shifts and some afternoons, and I will have to change it (no. 12). **(183)** I would not like to return to Spain to work as a nurse. Because I don't want to be called to work for two months, my contract runs out; they call me for another month, and my contract runs out… No. I instead work in the private sector or as a teacher (no. 12). **(184)** Here is a much quieter life. [pause] My partner and I need to interact more with Norwegian people, but our group is more Spanish [laughs] (no. 12). **(185)** It was difficult for me to adapt to meals and daylight hours in the beginning. I have lived in the north of Norway, and I have come to have only one hour of light a day. Psychologically it affects. I've been sad and tired (no. 13). **(186)** I had an incorrect perception of what a Norwegian was. They are pretty open people and have never closed the door to me about anything. But the culture is entirely different from Spanish (no. 14).	
Minor theme 16: Moments of discrimination in working places	
Spanish migrant nurses	
(187) There are occasions that I have experienced when some older patients have preferred to speak with Norwegians because of the language. "Can you pass the phone to another nurse because you don't understand me?" (no. 12). **(188)** There have been times when I have even wept because I felt attacked by someone. But that was a one-time thing (no. 12).	

(189) I am an intense person; I speak loud. Some have told me to calm down [laughs]. But I don't know if they put a good face on me, but then they think something else negative. Anyway, they treat me well. So I don't care (no. 12).
(190) Anyways, I think that the Spanish are pretty well seen here. Beyond the stereotypes I have been told about "siestas", I have been told that we are usually very hard-working and typically get our work done well (no. 12).
(191) I think that here the nurses get overwhelmed very quickly; perhaps it is because they are not used to the workload that we have in Spain (no. 13).
(192) As far as I know about nursing training, we are very, very well trained. In Norway, they raffle us and all the complicated techniques. If there is a Spanish nurse, they give them to her (no. 13).
(193) Once, they told me that a feeding pump had to be programmed for a patient, and a nurse jokingly told me that she had heard that Spanish nurses were very good at that [laughs]. "I make you a proposal, you program the pump, and I keep the phone and call the patients." (no. 13).
(194) I have not had a problem with anyone, but I have heard other Spanish colleagues say that they have had some racist problems with other nurses. Although not that much in reality, many Norwegians travel a lot to Spain or have houses there (no. 13).
(195) In general, they [Norwegian people] have made me feel like one of the team. Except in one place where I worked, which created anxiety because my colleagues were not good to me. Because you are a foreigner or you are new to the workplace. I have felt somewhat discriminated against (no. 13).
(196) I have been told that, according to other colleagues, some patients preferred other nurses based on skin colour (no. 14).
(197) I have noticed that healthcare academic training here is lesser than we have in Spain. Here we, the Spanish nurses, are appreciated for our knowledge and training (no. 14).
(198) It has also happened that I have been with a colleague who didn´t want to explain some things to me because of the language, and they entrusted specific tasks to others (no. 15).
(199) I miss more communication between colleagues. Here they go more to the basics; in Spain, we sometimes give unnecessary details (no. 15).
(200) Being Spanish, I may have felt a little forced to do something in some situations. Since I was a Spanish nurse, I was skilful, so I did things when it was a task for another colleague (no. 15).

Table S4. Magnitude of the derived qualitative findings.

	Major themes (magnitude in %)	Minor themes (magnitude in %)	Speech acts (magnitude in %)	Pattern A Major themes (magnitude in %)	Pattern A Minor themes (magnitude in %)	Pattern A Speech acts (magnitude in %)	Pattern B Major themes (magnitude in %)	Pattern B Minor themes (magnitude in %)	Pattern B Speech acts (magnitude in %)	Pattern C Major themes (magnitude in %)	Pattern C Minor themes (magnitude in %)	Pattern C Speech acts (magnitude in %)
Norwegian older patients	-	7 (43,8%)	69 (50,7%)	-	3 (18,75%)	34 (25%)	-	4 (25%)	35 (25,7%)	-	0	0
Spanish migrant nurses	-	9 (56,2%)	67 (49,3%)	-	3 (18,75%)	24 (17,6%)	-	4 (25%)	22 (16,2%)	-	2 (12,5%)	21 (15,5%)
In total	6 (100%)	16 (100%)	136 (100%)	3 (50%)	6 (37,5%)	58 (42,6%)	2 (33,3%)	8 (50%)	57 (41,9%)	1 (16,7%)	2 (12,5%)	21 (15,5%)

«Therapeutic collaboration in primary care for older people. An approach through critical discourse analysis»

This short presentation will give you some information about what we would like to investigate together...

The primary purpose of this research is to see if the attention the older patients receive is due to various considerations related to old age (or being older). This will be assessed based on autonomy and decision-making...

In other words: If older people are allowed to decide for themselves, or choose to do something, because they themselves believe they can do it. We want to investigate whether the older people are allowed to do this, or whether prejudice and other people's thoughts set limitations for the older patients.

The answers to this can be discovered through interviews and you have the opportunity to participate in an interview within a few days. The interview will last approx. 30 minutes (exact time spent will depend on each individual interview). The questions will be simply formulated and you are free to answer them however you wish. You can withdraw from the study at any time.

Thank you very much for your time and participation!

«Terapeutisk samarbeid i primæromsorgen for eldre menneske. En tilnærming gjennom kritisk diskursanalyse»

Gjennom denne korte presentasjonen vil du få litt informasjon om hva vi ønsker å gjøre sammen med deg...

Hovedformålet med denne undersøkelsen er å se om oppmerksomheten eldre får skyldes ulike hensyn relatert til alderdom (evt. det å være eldre). Dette vil bli vurdert ut fra autonomi og beslutningstaking...

Med andre ord: Om mennesker får lov til å bestemme over selv, eller velge å gjøre noe, fordi de selv tror de kan gjøre det. Vi ønsker å undersøke om eldre får lov til det å gjøre dette, eller om fordommer og andre menneskers tanker setter begrensninger for de eldre.

Svarene på dette kan bli oppdaget gjennom intervjuer og du har muligheten til å delta på et intervju innen få dager. Intervjuet vil vare ca. 30 minutter (eksakt tidsbruk vil avhenge av hvert enkelt intervju). Spørsmålene vil være enkelt formulert og du har frihet til å besvare dem slik du måtte ønske. Du kan når som helst trekke deg fra studien.

Tusen takk for din tid og deltakelse!

Scheme S2a. Interview script for Norwegian older patients.

Preliminary questions

11. How has your experience with nursing home care been?
12. Do you think they somehow treat you differently because of your age?
    a. [Yes] In which terms?
    b. [No] Why not? **Reasons**.

Appointments

13. When arranging an appointment, do nurses take you into account to establish the time slot for visits? [*care organisation*]

Nursing care services

14. Do you think the nursing care services you receive are those you really need? [*convenience*]
    a. [Yes] Do you receive those nursing care services when you need them? [*timely*]
    b. [No] Why not? **Reasons**.
15. Have you expressed your opinion regarding the nursing care services you receive or the treatment you take?
    a. [Yes] In which situations?
    b. [No] Why not? **Reasons**.

Nursing home visits

7. Do the nursing home visits adapt to your daily life/ lifestyle? [*balance*]
8. Do you consider the nurses to spend the necessary time you need with you? [*dedication*]
    a. In case of not: **Reasons**.
9. Do the nurses attend to any extra tasks you ask them in case of need?
    a. In case of not: **Reasons**.

Preferences expression and shared decision-making situations

3. Have you chosen something or decided something regarding your care?
    a. [Yes] In which situations?

i. Have you been able to do that the way you wanted to? [*coincidence*]

b. [No] Why not? **Reasons**.

Active participation situations

5. What is for you "to engage in your care"?
6. Do you think you engage as a patient in the nursing care services you receive?
    e. [Yes] In which situations?
        a. Did you want to engage then? And in that way? [*coincidence*]
    f. [No] Why not? **Reasons**.

Professional behaviours

7. When you have any preference or think about something related to your health condition: how is it to tell the nurses?
    a. [If easy] How do you do it?
    b. [If difficult] Why? **Reasons**.
8. Do you think the nurses listen to you if you want to share something with them?
    a. [Yes] Do the nurses follow your decision to be made?
    b. [No] **Reasons**.
9. Do the nurses do everything for you or encourage you to do something regarding your care? [*taking advantage of capabilities*]

Scheme S2b. Interview script for Spanish migrant nurses.

Preliminary questions

1. How has your experience with nursing home care been?
2. Do you think you somehow treat older patients differently?
    a. [Yes] In which terms?
    b. [No] Why not? **Reasons**.

Appointments

3. When arranging an appointment, do you consider the older patient to establish the time slot for visits? [*care organisation*]

Nursing care services

4. Do you think the nursing care services you give are those the older patients really need? [*convenience*]
    a. [Yes] Do you think you give those nursing care services when they need them? [*timely*]
    b. [No] Why not? **Reasons**.
5. Have you allowed the older person to give their opinion regarding the nursing care services you provide or the treatment they receive?
    a. [Yes] In which situations?
    b. [No] Why not? **Reasons**.

Nursing home visits

6. Do nursing home visits adapt to older patients´ daily life/lifestyles? [*balance*]
7. Do you consider you spend the necessary time older patients need with them? [*dedication*]
    a. In case of not: **Reasons**.
8. Do you attend to any extra tasks older patients ask you in case of need?
    a. In case of not: **Reasons**.

Preferences expression and shared decision-making situations

9. Have you allowed older patients to choose or decide about their care?
    c. [Yes] In which situations?

i. Have they been able to do that the way they wanted to? [*coincidence*]

d. [No] Why not? **Reasons**.

Active participation situations

10. What is for you "to engage in care"?
11. Do you think older patients engage in your nursing care services?
    g. [Yes] In which situations?
        a. Do you think they wanted to engage then? And in that way? [*coincidence*]
    h. [No] Why not? **Reasons**.

Professional behaviours

12. How do you think it is for older patients to tell you something?
    a. [If easy] How do they do it?
    b. [If difficult] Why? **Reasons**.
13. Do you think you listen to older patients when they want to share something with you?
    a. [Yes] Do you follow their decision to be made?
    b. [No] **Reasons**.
14. Do you do everything for the older patient or encourage them to do something regarding their care? [*taking advantage of capabilities*]

Cultural experience

15. From a cultural point of view, what has this experience meant to you? [personal/ work level]

16. Do you think that the fact of being Spanish has influenced something in this experience?

    a. [Yes] **Reasons.**
    b. [No] **Reasons**.

Bloque VI
Conclusiones sobre los Resultados obtenidos

Los resultados cosechados a raíz de la fenomenología crítica acerca de la experiencia de personas mayores que vivían solas en la comunidad sobre el momento de uso de servicios de salud señalaron una evidente telaraña cognitiva discriminatoria, donde imperaban las concepciones edadistas del personal sanitario hacia dichas personas mayores. Las relaciones de poder se vieron desequilibradas en perjuicio de las últimas tan pronto como el personal sanitario dedicaba respuestas que fueron percibidas por las propias personas mayores como discriminatorias, influenciando negativamente tanto el uso que hacían de los servicios de salud, como su APE.

Estos resultados fueron consistentes con la meta-síntesis y la nueva interpretación aportada al fenómeno de aparición de TDC, EP y PAC entre personas mayores y personal de enfermería comunitaria —fundamentados en la revisión sistemática de artículos cualitativos primarios—. Se hallaron elementos cruciales para el troquelado de situaciones de TDC, EP y PAC tales como el grado de desarrollo de cualidades comunicativas de las personas mayores y personal de enfermería constituyente de las relaciones de poder establecidas entre ambas. El contexto situacional y comunicativo representó un escenario que contribuía sobremanera a inclinar la balanza hacia el lado de la discriminación por edad, en aquellos casos en los que las situaciones de TDC, EP y PAC fueron escasas o inexistentes, origen todo ello de ideologías edadistas que infiltraban las mentes del grupo social correspondiente al personal de enfermería.

Los ECD resultaron ser un baño de realidad que confirmaba y daba más fuerza a los estudios mencionados hasta ahora. El género acabó por ser una

ficha sociocognitiva más para analizar de modo que, además de concepciones edadistas, también se entretejían concepciones paternalistas y autoimpuestas dependientes de los roles de género, que representaban un menoscabo en las relaciones de poder entre pacientes mujeres mayores y enfermeras de atención primaria. Las representaciones sociales proyectadas a través del discurso fueron construidas por medio del empleo de estrategias discursivas como la victimización, la polarización, intensificadoras de cualidades o el uso de metáforas, en concordancia con el cuadrado ideológico. La figura de las enfermeras de atención primaria fue la de un grupo social moralmente autoritario que responsabilizaba a las pacientes mujeres mayores, en ocasiones, de levantar una barrera comunicativa. La figura de las pacientes mujeres mayores fue la de un grupo social sutilmente dominado por el contexto laboral percibido de las enfermeras de atención primaria y sus decisiones tomadas unilateralmente con respecto a los cuidados.

Llevado el eje central de la presente tesis a otro nivel en lo que a contexto cultural se refiere, los resultados de los ECD en el contexto de atención domiciliaria de enfermería noruega, entre enfermeras migrantes españolas y personas mayores noruegas usuarias de estos servicios de salud comunitarios, dilucidaron las relaciones de poder entre ambos colectivos sociales. Desde el prisma de las personas mayores noruegas, se halló una representación social de persona mayor activa en los cuidados y ávida de participación, pero de inclinaciones polarizadas, habiendo grandes diferencias entre unos discursos más proclives a la figura de paciente agente, y otros más afines a la figura de paciente pasivo. Desde la mirada del discurso enfermero, las enfermeras españolas migrantes demostraron tener una afilada conciencia de valores promotores de la autonomía y participación de las personas mayores en

general, aunque el choque cultural de la experiencia en el contexto sanitario noruego impactó enormemente en las relaciones de poder establecidas, no solo con personas mayores noruegas, sino con sus propias compañeras de trabajo y el mismo sistema gestor de cuidados domiciliarios, el cual fue una influencia a veces negativa, para el adecuado desempeño enfermero en los hogares noruegos.

La presente aproximación a los ECD ha afianzado a los constructos socioculturales como los roles de género y el propio entorno cultural —tan hostil como maravilloso— como elementos que ahorman la balanza de unas relaciones de poder volátiles, dinámicas y mudables a su vez influenciadas por el marco ideológico del personal sanitario y las personas mayores. Por otro lado, se ha puesto de manifiesto que la contaminación edadista en la ideología de los cuidados está presente en todos los estratos del personal sanitario de primera línea de atención en la comunidad. Las cualidades comunicativas del personal sanitario resultan ser una potentísima y necesaria herramienta que cultivar para cincelar relaciones más equilibradas. La presente tesis ha llevado a la primera plana otro factor que ha pasado silenciosamente de puntillas pero que resulta ser clave para analizar las relaciones de poder en nuestro fenómeno de estudio: el contexto laboral que castiga tanto al personal sanitario con tiempos de atención encorsetados y con un usual déficit de plantilla profesional; que se erige como gran pilar de lo que podría llegar a ser, y no es, pudiendo lograr un (re)equilibrio en las relaciones de poder con respecto a situaciones de TDC, EP/EAP, y PAC (**Figura 11**).

Así, en el horizonte de estas investigaciones, hay un sueño utópico, si observamos la realidad de la presente tesis; un propósito futuro, si

observamos el camino que aún hay que emprender desde los ECD: la colaboración terapéutica en la atención comunitaria a personas mayores.

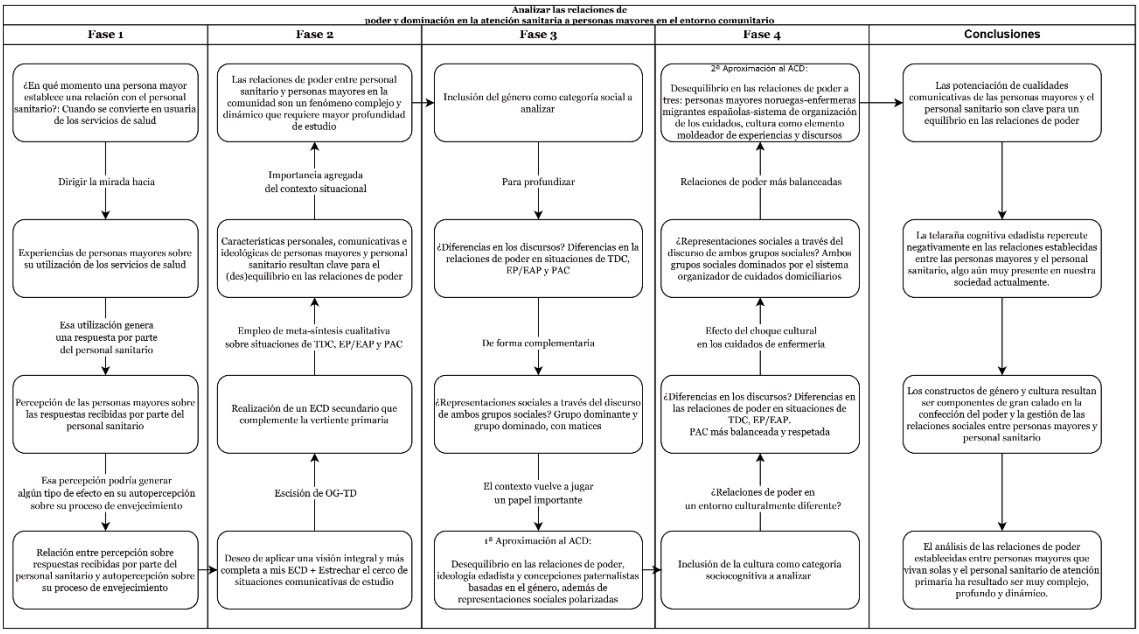


Figura 11. Hoja de ruta de la Tesis Doctoral y sus conclusiones. Elaboración propia.

Part VI
Conclusions on the Results obtained

The results harvested from the critical phenomenology about the experience of older people who lived alone in the community regarding the moment of use of health services indicated an evident discriminatory cognitive web, where the ageist conceptions of health personnel towards said older people prevailed. Power relations were unbalanced to the detriment of the latter as soon as the health personnel dedicated responses that were perceived by older people themselves as discriminatory, negatively influencing both the use they made of health services and their SPA.

These results were consistent with the meta-synthesis. A new interpretation is given to the appearance of SDM, EP and APC among older people and community nursing staff —based on the systematic review of primary qualitative articles. Crucial elements were found for stamping situations of SDM, EP and APC, such as the degree of development of communicative qualities of older people and nursing staff constituting the power relations established between both. The situational and communicative context represented a scenario that significantly contributed to tilting the balance towards age discrimination in those cases where the situations of SDM, EP and APC were scarce or non-existent, all originating from ageist ideologies that infiltrated the minds of the social group corresponding to the nursing staff.

My CDSs turned out to be a reality check confirming and strengthening the studies mentioned. Gender ended up being one more socio-cognitive file to analyse, so in addition to ageist conceptions, paternalistic and self-imposed concepts dependent on gender roles were also intertwined, which represented a reduction in power relations between older women patients and nurses of primary care. The social representations projected through the discourse were

built through discursive strategies such as victimisation, polarisation, quality intensifiers or metaphors following the ideological square. The figure of primary care nurses was a morally authoritarian social group that blamed older female patients, on occasion, for raising a communication barrier. The social projection of the older female patients was a social group subtly dominated by the perceived work context of primary care nurses and their unilaterally made decisions regarding care.

Taking the central axis of this thesis to another level regarding the cultural context, the results of my CDS in the context of Norwegian nursing home care among Spanish migrant nurses and Norwegian older patients users of these community health services elucidated the power relations between both social groups. From the perspective of Norwegian older people, we had a social representation of the older person active in the care and eager to participate but with polarised inclinations, with significant differences between some discourses more prone to the figure of a patient agent, and others more akin to the passive patient figure. From the point of view of the nursing discourse, the Spanish migrant nurses demonstrated a keen awareness of values that promote the autonomy and participation of older people in general. However, the culture shock of the experience in Norwegian healthcare enormously impacted power relations established, not only with Norwegian older adults but with their co-workers and the same home care management system. This was a sometimes-negative influence on adequate nursing performance in Norwegian homes.

The current approach to ECD has strengthened sociocultural constructs such as gender roles and the cultural environment itself —as hostile as beautiful— as elements that balance the volatile, dynamic and changeable

power relations that are in turn influenced by the ideological framework of health personnel and older people. On the other hand, it has been revealed that ageist contamination in the care ideology is present in all strata of health personnel on the front line of care in the community. The communicative qualities of healthcare personnel turn out to be a powerful and necessary tool to cultivate more balanced relationships. This thesis has brought to the fore another factor that has passed silently on tiptoe, but that turns out to be vital in analysing power relations in our phenomenon of study: the work context that punishes both health personnel with corseted care times and with a usual lack of professional staff; that stands as a great pillar of what could become, and is not, being able to achieve a (re)balance in power relations concerning situations of SDM, EP, and APC.

Thus, on the horizon of my investigations, there is a utopian dream if we observe the reality of this thesis; a future purpose if we look at the path that still has to be taken from the ECD: therapeutic collaboration in primary care for older people.

Del VI
Konklusjoner om resultatene oppnådd

Resultatene hentet fra den kritiske fenomenologien om opplevelsen til eldre mennesker som bodde alene i samfunnet med hensyn til øyeblikket av bruk av helsetjenester, indikerte et tydelig diskriminerende kognitivt nett, der de alderistiske oppfatningene av helsepersonell overfor nevnte eldre var rådende. Maktforhold var ubalanserte til skade for sistnevnte så snart helsepersonellet dedikerte svar som av eldre selv oppfattet som diskriminerende, og påvirket både bruken de gjorde av helsetjenester og deres SPA negativt.

Disse resultatene stemte overens med metasyntesen. En ny tolkning er gitt til utseendet til SDM, EP og APC blant eldre mennesker og sykepleiepersonell – basert på systematisk gjennomgang av primære kvalitative artikler. Det ble funnet avgjørende elementer for situasjoner med SDM, EP og APC, slik som graden av utvikling av kommunikative egenskaper hos eldre mennesker og pleiepersonell som utgjør maktrelasjonene som er etablert mellom begge. Den situasjonelle og kommunikative konteksten representerte et scenario som i betydelig grad bidro til å vippe balansen mot aldersdiskriminering i de tilfellene hvor situasjonene til SDM, EP og APC var knappe eller ikke-eksisterende, alle stammer fra alderistiske ideologier som infiltrerte til den sosiale gruppen tilsvarende pleiepersonalet.

CDS-ene mine viste seg å være en realitetssjekk som bekreftet og styrker de nevnte studiene. Kjønn endte opp med å bli enda en sosio-kognitiv fil å analysere, så i tillegg til alderistiske forestillinger ble paternalistiske og selvpålagte konsepter avhengig av kjønnsroller også flettet sammen, noe som representerte en reduksjon i maktforhold mellom eldre kvinnelige pasienter og sykepleiere i primærhelsetjenesten. De sosiale representasjonene som ble projisert gjennom diskursen ble bygget gjennom diskursive strategier som

offergjøring, polarisering, kvalitetsforsterkere eller metaforer som fulgte det ideologiske kvadratet. Personen som primærsykepleiere var en moralsk autoritær sosial gruppe som beskyldte eldre kvinnelige pasienter, noen ganger, for å heve en kommunikasjonsbarriere. Den sosiale projeksjonen til de eldre kvinnelige pasientene var en sosial gruppe subtilt dominert av den opplevde arbeidskonteksten til primærsykepleiere og deres ensidige beslutninger angående omsorg.

Ved å ta avhandlingen i denne oppgaven til et annet nivå når det gjelder den kulturelle konteksten, belyste resultatene av min CDS i sammenheng med den norske hjemmesykepleiesomsorgen blant spanske migrantsykepleiere og norske eldre pasienter brukere av disse samfunnshelsetjenestene maktforholdet mellom begge sosiale grupper. Fra norske eldres perspektiv hadde vi en sosial representasjon av den eldre personen som var aktiv i omsorgen og ivrig etter å delta, men med polariserte tilbøyeligheter, med betydelige forskjeller mellom noen diskurser som var mer utsatt for figuren som en pasientagent, og andre mer beslektet til den passive pasientfiguren. Fra sykepleierdiskursens synspunkt viste de spanske migrantsykepleierne en sterk bevissthet om verdier som fremmer autonomi og deltakelse for eldre mennesker generelt. Kultursjokket av erfaringen i norsk helsevesen påvirket imidlertid maktrelasjoner etablert, ikke bare med de norske eldre, men med deres medarbeidere og det samme hjemmetjenestens styringssystem. Dette var en til tider negativ påvirkning på tilstrekkelig sykepleieutførelse i norske hjem.

Dagens tilnærming til CDS har styrket sosiokulturelle konstruksjoner som kjønnsroller og selve det kulturelle miljøet – like fiendtlig som vakkert – som elementer som balanserer de flyktige, dynamiske og foranderlige

maktforholdene som igjen er påvirket av det ideologiske rammeverket til helsepersonell og eldre mennesker. På den annen side har det blitt avslørt at aldersforurensning i omsorgsideologien er til stede i alle lag av helsepersonell i frontlinjen av omsorgen i samfunnet. De kommunikative egenskapene til helsepersonell viser seg å være et kraftig og nødvendig verktøy for å dyrke mer balanserte relasjoner. Denne oppgaven har aktualisert en annen faktor som har gått stille på tå, men som viser seg å være avgjørende for å analysere maktforhold i vårt studiefenomen: arbeidskonteksten som straffer både helsepersonell med korsetterte omsorgstider og med vanlig mangel av personell; som står som en stor grunnpilar for hva som kan bli, og ikke er, å kunne oppnå en (re)balanse i maktforhold angående situasjoner med SDM, EP og APC.

På horisonten av mine undersøkelser er det altså en utopisk drøm hvis vi observerer denne avhandlingens virkelighet; et fremtidig formål hvis vi ser på veien som fortsatt må tas fra CDS: terapeutisk samarbeid i primæromsorgen for eldre menneske.

Bloque VII
Producción Científica derivada de la Tesis Doctoral

Capítulo I: Artículos Científicos en Revistas indexadas en JCR (Journal Citation Reports)

En las sucesivas líneas aparecen los artículos científicos que han sido publicados, aceptados o en vías de publicación. Estos artículos son fruto de las respuestas que el candidato al grado de doctor ha dado a los objetivos de la presente tesis:

- Martínez-Angulo, P., Muñoz-Mora, M., Rich-Ruiz, M., Ventura-Puertos, P. E., Cantón-Habas, V., & López-Quero, S. (2023). "With your age, what do you expect?": Ageism and healthcare of older adults in Spain. *Geriatric Nursing*, 51, 84-94. https://doi.org/10.1016/j.gerinurse.2023.02.020
  Indicio de calidad: [Factor de impacto (JCR 2021): **2,525**] [Nursing] [Rank: **36/125**] [Cuartil JIF: **Q2**]. Publicado.

- Martínez-Angulo, P., Rich-Ruiz, M., Ventura-Puertos, P. E., & López-Quero, S. Integrating shared decision-making, expressing preferences, and active participation of older adults in primary care nursing: a systematic review of qualitative studies and qualitative meta-synthesis. *BMJ Open*. **Indicio de calidad**: [Factor de impacto (JCR 2021): **3,007**] [Medicine, General and Internal] [Rank: **86/172**] [Cuartil JIF: **Q2**]. Pendiente de decisión final por parte del editor.

- Martínez-Angulo, P., Rich-Ruiz, M., Jiménez-Mérida, M. R., & López-Quero, S. Active listening, shared decision-making and participation in care among older women and primary care nurses: a critical discourse analysis approach from a gender perspective. *BMC Nursing*.
  Indicio de calidad: [Factor de impacto (JCR 2021): **3,189**] [Nursing] [Rank: **18/125**] [Cuartil JIF: **Q1**]. Revisión por pares.

- Martínez-Angulo, P., Rich-Ruiz, M., Ventura-Puertos, P. E., & López-Quero, S. Analysing Power Relations among Norwegian older patients and Spanish migrant nurses in Home Nursing Care: A Critical Discourse Analysis approach from a Transcultural perspective. *Healthcare*.
  Indicio de calidad: [Factor de impacto (JCR 2021): **3,160**] [Health care sciences & Services] [Rank: **50/109**] [Cuartil JIF: **Q2**]. Aceptado para publicación.

Capítulo II: Comunicaciones Científicas

Sección I: Formato Oral

Asimismo, he aquí una relación en orden cronológico ascendente de las comunicaciones científicas en formato oral y póster derivadas de la presente tesis doctoral:

- **Toma De Decisiones Compartida, Expresión De Preferencias Y Participación Activa De Pacientes Mayores En La Enfermería De Atención Primaria: Una Revisión Sistemática Cualitativa Y Metasíntesis.** Comunicación formato oral en el "*XI Congreso científico de personal investigador en formación (PIF)*" organizado por la Formación de Escuelas Doctorales de la Universidad de Córdoba, celebrado en la Facultad de Medicina y Enfermería, en Córdoba el día 4 de mayo de 2023.
- **Relaciones de poder en el contexto de los cuidados de enfermería domiciliaria a mujeres mayores: una aproximación de análisis crítico del discurso con perspectiva de género**. Comunicación formato oral en el "*I Encuentro Científico sobre Investigación con Perspectiva de Género*" organizado por la Universidad de Córdoba, celebrado en el Salón de Actos del Rectorado de la Universidad de Córdoba el día 14 de febrero de 2023.
- **"Con tu edad, ¿qué esperas?": Edadismo, autopercepción de envejecimiento y cuidados recibidos en pacientes mayores**. Comunicación formato oral en el "*XXVI Encuentro Internacional de Investigación en Cuidados*" organizado por INVESTÉN, celebrado del 16 al 18 de noviembre de 2022 en Pamplona.
- **Toma de decisiones y enfermería a domicilio: una aproximación de análisis crítico discursivo**. Comunicación formato oral en el "*VIII Congreso Científico de Investigadores en Formación de la Universidad de Córdoba*" organizado por la Escuela de Doctorado de la Universidad de Córdoba, celebrado en Córdoba los días 18 y 19 de febrero de 2020.

Sección II: Formato Póster

- **Relaciones de poder, choque cultural y cuidados en la persona mayor: un estudio de análisis crítico del discurso sobre enfermeras migrantes españolas en Noruega.** Comunicación formato póster en el "*I Congreso Internacional Multidisciplinar de Estudiantes de Doctorado*" organizado por la Universidad de La Laguna, celebrado del 22 al 24 de marzo de 2023 en formato semipresencial en San Cristóbal de La Laguna (Tenerife, España).

- **Toma de decisiones y cuidado en una paciente mayor: análisis crítico discursivo de un caso de enfermería domiciliaria**. Comunicación formato póster en el "*XXIV Encuentro Virtual Internacional de Investigación en Cuidados*", organizado por INVESTÉN y celebrado virtualmente en Pamplona, del 9 al 13 de noviembre de 2020.

Bloque VIII Documentación Anexa de la Tesis Doctoral

1. Aproximación al ACD realizada en español a Pacientes Mujeres Mayores Españolas

1. **Aproximación al corpus de estudio.**

   En este ejercicio próximo al ACD, se han seleccionado los momentos más informativos extraídos de las transcripciones de cada una de las entrevistas. Para elaborar dicha selección, el autor realizó una lectura inmersiva de las transcripciones, en primer lugar, para familiarizarse con el corpus de estudio; el autor realizó una segunda lectura comprensiva para identificar los niveles del discurso a los que el corpus invitaba a dirigirse, en segundo lugar, adaptándose así a la esencia de las declaraciones de las participantes; el autor realizó una tercera lectura focalizada para llevar a cabo la elección correspondiente de los fragmentos sensibles a analizar, en tercer lugar.

2. **Aproximación al ACD.**

   A continuación, se desarrollará de manera ordenada la aproximación al ACD de los momentos informativos de las participantes, apoyándose el autor en los verbatim extraídos que reflejen lo analizado, destacando en una relación ordenada el análisis de los planos pragmático, sintáctico, semántico, conversacional, retórico-estilístico, cognitivo y la descripción de estrategias discursivas desplegadas por las participantes.

*3.1. **Análisis de actos de habla.***

3.1.1. Posible diferencia en el trato por el hecho de ser mayor o tener edad avanzada.

(1) No, te tratan bien, te tratan bien. No sé si es porque somos más mayores, ¿sabes? (PAC1).

(2) Eh… Hombre, diferente no, pero que algunas veces te han dicho, y con la edad que tiene usted ya, ¿qué quiere? (PAC33).

(3) [haciendo referencia a (2)]Hombre, en aquel momento… No me pareció bien. Pero bueno, verás, que… Que tampoco hay que darle más importancia (PAC33).

En (1), el acto de habla va seguido de una presuposición que asume que de no ser mayor, el trato no sería tan bueno o al menos, no el mismo. Abre con un enunciado directo y afirmativo, con la construcción reiterativa *te tratan bien*, que actúa como intensificadora de la afirmación previa. La construcción verbal *No sé* que abre el segundo enunciado, sin embargo, choca frontalmente con la afirmación anterior, restándole entidad y marcando la posibilidad de que sea algo puntual o en cualquier caso, no reglado. La conjunción condicional *si* da paso a un argumento coorientado relevante, con fuerza argumentativa, que parece reforzar esa oposición. El uso del marcador retórico *¿sabes?* deja la puerta abierta a la interpretación del entrevistador si esto es así en realidad, por lo que aparece la siguiente presuposición cognitiva: las personas mayores se merecen un buen trato. Por otro lado, ese mismo marcador invita a que el entrevistador dé su opinión con respecto a esta disyuntiva, creando una imagen de horizontalidad, cercanía y escucha activa en la conversación.

En (2), el marcador discursivo conversacional *Eh…* denota algo de desconcierto ante la pregunta planteada, indicador de que no era esperada por parte de PAC33. Tras dos segundos de pausa, el marcador introductorio *Hombre* [utilizado también en (3)] descarga la sensación de gravedad de la pregunta, algo materializado en la aseveración que le sigue. Sin embargo, el conector *pero* rectifica la negación anterior, introduciendo una argumentación indirecta proveniente de la profesional que la espetó. El uso del pronombre personal átono de segunda persona del singular *te*, contiene una fuerza ilocutiva notable, al transferir el locus de identidad al entrevistador, situándolo en el punto de mira de una declaración que propone una situación claramente diferenciadora. Por tanto, su primera negación se desviste hasta caer, precisamente, en una afirmación: es tratada de forma diferente.

En (3), el esqueleto pragmático es prácticamente el mismo que en (2), con el añadido de la conjunción *que* encabezando una oración subordinada con antecedente implícito. El marcador *que* cobra fuerza ilocutiva cuando se refuerza con la construcción *Que tampoco*, precedida por un silencio de apenas un segundo. El compendio de estos elementos facilita intuir que en realidad, sí es algo a lo que PAC33 le dé importancia.

3.1.2. Organización de la atención. Adaptación del personal sanitario a la vida diaria de las pacientes. Aviso y/o pacto de las visitas domiciliarias.

(4) Hombre… (risas) Si a lo mejor… a lo mejor, pues eso, que me llaman. Y tengo cita para la peluquería. ¿Qué le digo a la peluquera ahora que no voy? ¿Y qué le digo a ella que no venga? (risas) Ya, me pongo en duda,

me pongo en duda (PAC1).

(5) [¿y qué es lo que hace?] Pues ir a la peluquería, porque mira. La enfermera puede pasar porque me encuentro bien y yo no necesito ahora mismo… Y la peluquería me hace falta porque voy a salir. Y tomo la decisión de ir a la peluquería (PAC1).

(6) No, vienen directamente y si no estoy, pues se van, las criaturas. Que yo tampoco les puedo exigir una hora porque ellas tienen mucho trabajo (PAC4).

(7) No, algunas veces viene porque le tocaba, tenía ella un día fijo, siempre, los dos últimos días de mes siempre venía. Y ya no avisaba, se presentaba… ¿Sabe usted que me toca? Ay, [nombre de la enfermera], cómo vienes y no… (PAC6).

(8) [¿y a usted le gustaría que le avisara con…?] Hombre, me gusta más que me avise porque como estoy sola, algunas veces estoy con bata, algunas veces estoy… (risas) (PAC6).

(9) Como yo estoy aquí, pues la hora que ella puede. Y ahora más, que como se han ido unos pocos de vacaciones… (PAC7).

(10) No, ella me suele llamar y me dice mira, que voy a pasar a inyectarle. Ah, pues bien, ya está, ya sé yo que va a venir, pues ya… estoy yo aquí preparada, tranquila (PAC33).

En (4), el marcador del discurso *Hombre*, acompañado de una risa, hace tambalear la rotundidad y seguridad de la respuesta que le sigue. La conjunción condicional introduce aquí una construcción de palalelismo sintáctico de ambigüedad que, intercalada por un breve silencio, se repite ("Si a lo mejor… a lo mejor"). Esto actúa como intensificador de falta de

rotundidad en la afirmación de que la llaman, apoyada por el marcador *pues eso*, vacío de significado causal pero lleno de significado pragmático: PAC1 tiene dificultades para argumentar a favor del buen hacer de las enfermeras en este aspecto. Añade abruptamente mediante la conjunción copulativa *y* una situación que le generó un conflicto relacionado con la pregunta, por lo que se destila cierta incomodidad al resultar tan directa e inconexa, aparentemente, con su enunciado anterior. Le sigue un acto de habla indirecto implicativo con una presuposición efímera, cuando PAC1 lanza dos preguntas retóricas y presupone que no es su responsabilidad en ese preciso instante decidir si atender un servicio u otro. Ríe de manera distendida cuando introduce el conflicto, con el objetivo de crear complicidad con el entrevistador y así trasmitir confianza en la situación comunicativa. Su risa simboliza un acto de cortesía para favorecer su imagen pública de paciente y mitigar un acto de habla irónico que roza lo descortés. La construcción sintáctica *me pongo en duda* que cierra su enunciado, sirve de intensificadora del conflicto al verse duplicada de seguido, por lo que PAC1 hace explícita, de manera implícita, su incomodidad al vivir ese compromiso de elección al que las enfermeras la hacen enfrentarse.

En (5), la sensación de inseguridad da un vuelco con la rotundidad de sus declaraciones, siendo estas más escuetas y directas, mediante el uso del marcador locativo *pues mira*, localizando la consecuencia a continuación. La construcción *La enfermera puede pasar* resulta una manera particular de decantar la balanza de la decisión hacia el otro lado, significando aquí que puede prescindir de sus servicios. PAC1 establece a partir de entonces un paralelismo causal que justifica su elección del

servicio, *porque me encuentro bien*, desecha el primero; *porque voy a salir*, recibe el segundo. Resulta notoria la forma en la que PAC1 finaliza con un acto de habla asertivo (*Y tomo la decisión de ir a la peluquería*), por su entidad, claridad y seguridad, con fuerza ilocutiva que la hace adquirir aparentemente una imagen de rol de poder, de elección. Sin embargo, esto podría considerarse un espejismo de situación de toma de decisiones, ya que PAC1 cree estar decidiendo, pero se ha visto abocada, en realidad, a decidir algo que vino impuesto previamente por una situación de conflicto que decidió en primer lugar la enfermera: no adaptarse a la actividad anteriormente programada por PAC1. Por tanto, el verdadero rol de poder, lo ostenta la enfermera.

En (6), PAC4 inicia su intervención con un acto de habla (*No, vienen directamente y si no estoy, pues se van*) directo y añade al final del mismo un componente metafórico (*las criaturas*), con gran fuerza pragmática e ilocutiva. Este recurso cumple aquí dos funciones: la primera, muestra por parte de PAC4 una actitud compasiva y exenta de locus de poder, renunciando así a la posibilidad de que se coordinen con ella, ya que está conforme con eso; la segunda, crea una imagen pública de ternura y paciente dócil que se siente afligida cuando las enfermeras, aun no habiendo consultado previamente con ella la hora de visita, acuden a su domicilio y no está presente. La responsabilidad, pues, recae en PAC4 por no encontrarse en casa, y no en las enfermeras, por no haber pactado el horario de visita con anterioridad. Todo esto se ve con mayor claridad cuando abre el segundo enunciado con la construcción *Que yo tampoco les puedo exigir*, claramente intensificadora de una actitud de sometimiento a las circunstancias del personal de enfermería. El deíctico *yo* y el adverbio

tampoco la hace atarse a sí misma de manos, y la utilización del verbo *exigir* detenta connotaciones de dominación, que ella interpreta que provocaría si contemplara la posibilidad de hablarle a las enfermeras sobre el horario de visitas, confundiendo así un derecho como paciente, con un ejercicio desmesurado de poder que ella considera que no le corresponde.

En (7), las visitas comienzan con una naturaleza irregular mediante la construcción adjetival *algunas veces*, pero rápidamente adquieren un componente sistemático (*porque le tocaba, tenía ella un día fijo*), intensificado por el adverbio de frecuencia *siempre*. Esta aparente contradicción, en primera instancia ilógica, cobra sentido cuando añade mediante la construcción copulativa *Y ya no avisaba, se presentaba…*, la cual denota que ni la propia PAC6 sabía con exactitud cuándo iba a ser visitada por la enfermera, algo que la desconcertaba y le generaba inquietud. El silencio que le sigue se presenta como un silencio catafórico, al translocar un diálogo enfermera-paciente que se dio en el pasado, al diálogo entrevistador-paciente que se da en el momento presente. Este diálogo introducido refuerza y disipa ese principio ilógico, dando lugar a una situación incómoda para PAC6, la cual ilustraba una interferencia en el cuidado.

En (8), siguiendo la línea sembrada por (7), el marcador del discurso *Hombre*, genera alivio y deseo al ser preguntada por algo que esperaba. Por ello, explicita su preferencia, pero el uso del adverbio de cantidad *más* nos dice que en ningún momento hemos de presuponer que no le gusta que no la avisen (*me gusta más que me avise*), por lo que su rol de paciente pasivo aflora en ese momento: ella se siente incómoda cuando no la avisan, prefiere de hecho que la avisen, pero está conforme igualmente cuando no lo hacen.

Esto se ve reforzado por un argumento de intensidad introducido por el conector explicativo *porque*, donde PAC6 ejemplifica con su realidad diaria lo que ocurre cuando no la avisan, dejando libre a la imaginación del entrevistador el abanico de posibilidades que se pueden dar en las que PAC6 no se encuentra en condiciones de recibir a las enfermeras, acompañando de una risa que funciona como órdago de complicidad y cercanía.

En (9), la contestación reside en un acto de habla indirecto, no explicitando en ningún momento si la avisan o concretan la visita con ella en algún punto temporal: no hay una afirmación o negación directa. Nos fuerza a realizar una presuposición, deslizando el testigo de que el entrevistador sea el que decrete esto. Se trata de una intervención conformada por dos enunciados igualmente ambiguos, pero poderosamente ilocutivos. Con el primero (*Como yo estoy aquí, pues la hora que ella puede*), la construcción sintáctica causa-efecto nos informa de su incapacidad de decisión. El control de la situación la transfiere a la enfermera, pues es el elemento que decide cuándo acudir, contando con que el otro elemento, permanece a la espera. De esta forma, PAC7 queda a merced de la aparición de la enfermera, obstaculizando la realización de sus actividades de la vida diaria. El segundo enunciado copulativo (*Y ahora más, que como se han ido unos pocos de vacaciones…*) juega como intensificador de su estatus de sujeto paciente, sometiendo a PAC7 a la realidad laboral. Esa realidad de carecer de personal suficiente que dé cobertura a las pacientes adquiere además un papel justificativo del porqué la enfermera tiene "permiso" para ejercer el control. PAC7, pues, asume como parte de "su" mundo real una coyuntura que no debería formar parte del mismo, porque no le corresponde y se escapa a su poder actuación.

En (10), ocurre un enmascaramiento de una situación sensible a ser consensuada con PAC33. Por un lado, *No, ella me suele llamar y me dice mira, que voy a pasar a inyectarle*, representa un acto ilocutivo donde la enfermera levanta una cortina de humo al avisar a la paciente de su visita. Sin embargo, no lo hace con ánimo de coordinarse con ella, sino para informarla de su decisión, algo que debería hacerse entre las dos. El verbo conjugado de frecuencia *suele* nos pone en perspectiva de que se tratan de situaciones asiduas. Por otro lado, *Ah, pues bien, ya está, ya sé yo que va a venir, pues ya… estoy yo aquí preparada, tranquila*, la consecuencia del acto ilocutivo anterior, con matices ligeramente impregnados de molestia e incluso rozando la ironía. Esto se logra mediante un uso de los marcadores *Ah* y *ya*, sobre todo del último repetido tres veces en apenas una línea de diálogo; el paralelismo sintáctico de *ya está, ya sé*; el uso de un breve silencio que arrastra al marcador *ya*; el uso de oraciones cortas, en ocasiones con apenas una o dos palabras. Este segundo enunciado nos puede transmitir sensación de disconformidad velada, que suma al enunciado anterior.

3.1.3. Comunicación con el personal sanitario: necesidades, deseos, emociones, estados de ánimo, dudas.

(11) No. Yo si me encuentro mal, consulto con mi hermana. Y ya está. Tengo más confianza con ella (PAC1).

(12) Yo digo muchas veces, opino yo para mí. […] Lo pienso yo. Lo pienso para mí, pero no para… decírselo a la nadie (PAC1).

(13) Pues sí, lo tenía que contar (PAC1).

(14) No, porque si ella tiene que hacer otra cosa, y ya está, y sabe que yo estoy

atendida, que yo tengo una mujer, que yo no estoy sola (PAC2).

(15) Me resulta... A mí no me importa. Pero como no tengo problemas que contarle, nada... ¿Qué cuento? (Risas) (PAC2).

(16) Yo lo que le digo muchas veces es que se me hacen las tardes muy largas (PAC2).

(17) [en referencia al médico]¿Sabes? Y se lo dije, que no me la mandara [un tipo de pastilla]. Que no me la mandara porque me estuvo haciendo muchas pruebas de la sangre, cómo la tenía. Pero... nada. Ni porque le supliqué (PAC3).

(18) [en referencia a la enfermera]No. A mí me da mucha fatiga de eso. Ea, porque yo digo ellas tienen su trabajo, tienen sus controles, sus cosas y no voy a estropeárselas yo (PAC3).

(19) No, no es que yo... Y ni a mis hijos quiero molestarlos. Y cuando me duele algo la mitad de las veces no se lo digo ni a mis hijos. [...]¡Porque no quiero que sufran! Bastante estoy sufriendo yo... (PAC3).

(20) Todo se lo pregunto, todo se lo consulto. Todo me lo contesta. Nada, nada, no pasa nada. ¿Le tengo que servir algo de comida, algo, de merendilla? (PAC6).

(21) Nunca. No, no, es que no se lo he dicho nunca. Si cambia de día o lo que sea, ella sabrá por qué. ¿No lo tiene usted... así...? Con cariño [aclarando en qué tono le dice la enfermera lo anterior]. ¿No le tengo a usted dicho que los dos días últimos del mes, en ese voy? El 24 y el 25. Y yo no... No tengo queja de que no me lo diga ni de... Ni yo intento decirle ni preguntarle. Yo la dejo hacer. Porque ella vale mucho. Mucho. Yo no le pregunto nada, ella va haciendo... Subiendo, bajando el día que puede, y el día que no puede no viene y no pasa nada (PAC6).

(22) Yo la dejo hacer, vamos, como si fuera una madre (PAC6).

(23) Porque parece ser que… rechazarle su trabajo, cuando ella lo lleva así… Si lleva esas [referencia a medicación], es porque las necesito. Y cuando no las necesito me las dice, déjelas usted ahí (PAC6).

(24) [en referencia la médico]Me viene aquí, lo primero que hace mira ese cajón porque ahí es donde tengo las medicinas. Él sabe que yo no colecciono… que no soy como muchas que tienen… No, no, no. Yo lo justo. Y dice, voy a mirar a ver lo que tienes. Y me dice, dice, bueno ¿y para qué me llamas? Digo, llamo porque me pasa esto. Dice, tú lo que quieres es que te vea, ¿no? Dice, es tontería, si no te puedo mandar medicina porque tienes alergia. No te puedo mandar nada. Digo, ah, pues entonces adiós (PAC8).

En (11) y (12), PAC1 sigue un mismo hilo conductor caracterizado por la contundencia y hermetismo con respecto al personal de enfermería. El deíctico *yo* aparece tres veces, reforzado además por las construcciones discursivas *y ya está* y *para mí*, esta última dos veces. Si estas estrategias no fueran suficientes, cobra especial relevancia el paralelismo sintáctico *Lo pienso* que, no solo aparece seguido uno detrás de otro, sino que apoyándose en lo descrito anteriormente, gana una gran fuerza perlocutiva, generando la sensación de autonomía y poder de decisión. Sin embargo, el hecho de decidir no compartir pensamientos con las enfermeras —facto de autonomía y legitimidad—, a su vez representa un sabotaje en su relación con las mismas, pues a continuación, expresa en (13) su arrepentimiento verbal al no hacerlo. No obstante, resulta llamativo observar la forma verbal *lo tenía* [que contar], pues al dirigirse al pasado y no al presente, habla sobre

una oportunidad perdida, y no potencial, por lo que facilita presuponer que ahora no lo tiene porqué contar.

En (14), PAC2 divide el enunciado en dos bloques, unido mediante el recurso argumentativo conector *y sabe*. Por un lado, en el primer bloque (*No, porque si ella tiene que hacer otra cosa, y ya está*) atribuye el hecho de no decirle algo a la enfermera a la presuposición de que la profesional no puede dedicarle más tiempo, añadiendo al final de esta declaración el recurso intensificador de certeza *y ya está*. Por otro lado, el segundo bloque dirige la presuposición esta vez al rol de la enfermera, o dicho de otro modo, hace presuponer a la enfermera que PAC2 no necesita decirle nada porque está bien abastecida. Sin embargo, es notorio que, bajo la apariencia de rotundidad y seguridad, los argumentos adquieran una fuerza ilocutiva compasiva, al desplazar el locus de acción fuera de su autonomía como paciente, creando una imagen pública de sujeto paciente y no de agencia, quedando despojada del derecho a decidir. Al mismo tiempo, utiliza un recurso intensificador de contenido semántico positivo, con una estructura nuclear pragmática verbal y la intención de insertar un mensaje tranquilizador mediante una estructura sintáctica paralela.

En (15), se aprecia un acto de habla dubitativo, en una parte del primer enunciado donde introduce un verbo de naturaleza opinativa que frena en seco tras un breve silencio, para redirigirse a un plano afirmativo. Este estado de inseguridad se ve clarificado por la mediación del conector *pero*, con una función rectificadora que parece regular la afirmación anterior. Por tanto, se desprende la presuposición de que PAC2, en el caso de que considerase tener algún problema, sería posible que sí le importara el comunicarlo. Esto se ve reforzado por la pregunta retórica acompañada

de una risa al final de su declaración, estableciendo un tono de cierta ligereza y ficción en el supuesto que anteriormente afirma. Siguiendo con PAC2 en (16), vemos cómo este matiza lo dicho en (15) al declarar contrariamente que sí comunica ciertos aspectos al personal de enfermería. Sin ir más lejos, la construcción frecuentativa intensificadora *muchas veces* nos indica que es algo recurrente. Resulta especialmente interesante el argumento que utiliza para declarar que sí que mantiene una comunicación con la enfermera: *es que se me hacen las tardes muy largas*, teniendo el operador *es que* valor conclusivo. Por otro lado, la expresión estilística utilizada tiene una gran carga ilocutiva, desplazando el locus de acción a un sustantivo inanimado (*las tardes*) con la utilización de una forma verbal carente de agencia (*se me hacen*). Esto nos hace ver que PAC2 carece de control y poder para revertir la situación, quedando a merced de lo que el oyente pueda sugerir u opinar al respecto. Dicha expresión tiene un fondo metafórico, abstracto, otorgando a un fenómeno natural como es el paso del tiempo, la capacidad de moldear el mundo real de PAC2, teniendo una intencionalidad proclive a la creación de compasión y empatía. Retomando el testigo de (15), PAC2 dejaba entrever que no tenía comunicación con la enfermera porque no consideraba que hubiera algún problema del que informar. Ese mismo precepto nos permite establecer una relación lógica en (16): si en (15), no comunicación = no problema, entonces en (16), comunicación = problema. La presuposición que emerge, pues, es que PAC2 considera un problema que pase mucho tiempo sola en su domicilio.

En (17), el marcador discursivo *¿sabes?* atrae la atención para añadir mediante la conjunción copulativa *y* el argumento. En el enunciado, PAC3 hace gala de una acto de habla ilocutivo sutil, ya que por la manera en que

construye su declaración, provee de una intención de insistencia, aseveración. La primera parte, precedida del pronombre personal *se* como complemento indirecto acompañante al pronombre *lo*, cobra connotación de aviso e insistencia. La segunda parte, introducida por el conector *que*, explicita verbalmente la insistencia primaria (no mandarle la pastilla), por lo que esta segunda parte se convierte en una insistencia secundaria. Encontramos una tercera parte, como recurso intensificador mediante un paralelismo sintáctico anadiplótico, que engancha con la justificación que sustenta la razón de su insistencia (*…que no me la mandara. Que no me la mandara poque…*). Finalmente, como anticlímax de su ilocución insistente, mediante el conector *pero* niega la realidad de lo expuesto anteriormente, acompañado de un breve silencio culminado por la inmensidad del pronombre indefinido *nada*. Añade mayor sensación de decepción la declaración que cierra su enunciado, utilizando un verbo de connotaciones cercanas al sometimiento y dominación (*ni porque le supliqué*).

Siguiendo con PAC3 en (18), sigue habiendo un aroma a contundencia en sus declaraciones, apoyado por la interjección *Ea* que da pie a que desmenuce esa contundencia con un argumento coorientado. Especial relevancia cobra la perífrasis verbal con sentido de futuro próximo y el verbo principal elegido (*no voy a estropeárselas yo*), con una fuerza ilocutiva que nos hace detectar un estado que cruza la fina línea entre no comunicar por inexistencia de necesidad y no comunicar por considerarse una carga, representándose a sí misma como una molestia para el desempeño de las labores de enfermería. La utilización de elementos con connotaciones pragmáticas en este plano parece apuntar a una dirección de no ser asertiva con su derecho como paciente de comunicar, ya que de

hacerlo, “estropea sus cosas”, sintiendo “fatiga” con tan solo plantearlo. El esqueleto pragmático se repite en (19), dejando aún más claro lo expuesto con anterioridad al identificar varios elementos: la introducción de un nuevo actor en la conversación, los hijos, a quien no quiere *molestarlos*; la utilización de construcciones con gran fuerza ilocutiva, *ni a mis hijos quiero molestarlos*, *no quiero que sufran*; la utilización de exclamaciones, traducidos al nivel conversacional como intensificador del mensaje. Este mensaje resulta ser grave, sobre todo cuando explícitamente reconoce que ni a sus hijos comunica situaciones de conflicto, en este caso, dolor. En este sentido, PAC3 adopta un rol de mártir, acompañado de una imagen pública de asunción de su estado de salud, de aceptación de este. Se desprende un sentimiento de culpa (*Bastante estoy sufriendo yo…*) que bloquea no solo la comunicación con el personal sanitario, sino con su propia familia. Se trata, pues, de un estado de sometimiento y dominación no tanto por parte de las enfermeras en este plano, sino de su propia condición e ideología. PAC3 parece discriminarse a sí misma mediante el uso de estos mecanismos discursivos.

En (20), tenemos en cambio un giro de ciento ochenta grados con respecto a la relación que PAC6 guarda con la enfermera. El paralelismo sintáctico (*Todo se lo pregunto, todo se lo consulto. Todo me lo contesta*), unido a una repetición de carácter intensificador (*Nada, nada, no pasa nada*) además de acuñar una formulación directa al entrevistador, simulando una situación real con la enfermera, hace del acto de habla de esta paciente un acto ilocutivo importante de intencionalidad desinteresada y rozando connotaciones relativas a la servidumbre con la utilización de estrategias de cortesía robustas, como puede ser la utilización del leísmo de

cortesía (*¿le* tengo que…?); verbos de calado pragmático (*servir*); diminutivos, con el propósito de crear cercanía y complicidad, al mismo tiempo de restarle carga al hecho de prepararle algún aperitivo a la enfermera (algo de *merendilla*). Sin embargo, resulta poderosamente sorpresivo que esa comunicación tan reiterada y terapéutica, desaparezca de bruces cuando el acto de comunicar cambia de perspectiva. En (20), estaba enfocado en la comunicación de cuestiones personales, mientras que en (21), se enfoca en cuestiones profesionales, y es ahí donde PAC6 desempeña un rol de sometimiento al profesional que se ve reforzado por estrategias discursivas como: el uso de *nunca* como adverbio de negación y tiempo, además de la partícula negativa *no*, llegando a utilizar cinco términos de negación en apenas una sucesión de once palabras; traslocación de la responsabilidad, al presuponer PAC6 que el cambio de cita no es algo que ella pueda ni deba controlar (*Si cambia de día o lo que sea, ella sabrá por qué*); ejemplificación directa extraída de una conversación pasada para justificar que el error recae en sí misma y no en la enfermera (*¿No le tengo a usted dicho que los dos días últimos del mes, en ese voy?*) —la construcción sintáctica *¿no le tengo a usted dicho que…?* tiene una fuerza ilocutiva importantísima, al tratar de hacer ver a PAC6 que ya debería saber de antemano de su visita, despojándola así de cualquier oportunidad de disentir y pasándole el testigo de la carga perjuiciosa de la situación comunicativa creada—; excusa de la intervención proveniente de la enfermera, con una fuerza ilocutiva exculpatoria (*Con cariño*). Además, apuntala ese sentimiento casi de deuda con la enfermera por medio de estrategias que vuelven a desplazar a la paciente de un locus de control, dando vía libre a la enfermera a gestionar la atención a su antojo;

explicitando verbalmente su conformidad (*No tengo queja de que no me lo diga ni de…*); eliminando de raíz su potencial de implicación en sus cuidados al utilizar la doble negación *Ni yo intento decirle ni preguntarle*, que a su vez actúa como estructura catafórica (*Yo la dejo hacer*). Este estatus de inanición tiene especial relevancia si nos dirigimos a (23), donde PAC6 utiliza una expresión clave (*Porque parece ser que… rechazarle su trabajo, cuando ella lo lleva así…*), con el empleo de un verbo conjugado con alto componente pragmático (*rechazarle*), fiel reflejo del efecto perlocutivo que en ella infunde la actuación de las enfermeras. En (23), establece una relación de causalidad mediante el *si* condicional: si hace esto [ella, enfermera], esto necesito [yo, paciente]. Y si no lo necesita, la enfermera mediante un acto de habla descortés deja claro que es la que debe decidir sobre cómo gestionar la situación. Volviendo a (21) y para continuar con su extensa justificación, introduce mediante el conector *porque* lo que sería el argumento principal (*ella vale mucho*), auxiliado por el adverbio de cantidad que se repite inmediatamente y actúa como intensificador que, a su vez, cobra mayor sentido mediante la utilización de recursos estilísticos como la metáfora en (22), donde establece una relación simbólica directa entre enfermera-paciente y madre-hija. En (21), vuelve a dar un giro y enfocarse en su no-agencia (*Yo no le pregunto nada, ella va haciendo…*), para retornar de nuevo en la expiación de la enfermera (*y el día que no puede no viene y no pasa nada*). Revisando el discurso de PAC6 como conjunto, parece que en algunos momentos hay lagunas de cohesión, botando entre argumentos de manera desordenada y recurriendo a la repetición. Sin embargo, esto puede considerarse como una estrategia discursiva en sí misma, pues, ante la falta de una argumentación férrea y

una relación de fondo terapéutico, PAC6 opta por pilotar de manera errante su intervención para intentar distraer al entrevistador del verdadero mensaje que se esconde tras esa autopista: PAC6 parece estar sometida al personal de enfermería principalmente por dos cuestiones. La primera, las estrategias discursivas empleadas por las enfermeras al inclinar la balanza hacia su lado. La segunda, la ideología de la paciente y su cognición acerca de lo que debe suponer la relación enfermera-paciente.

En (28), es apreciable que situaciones de sometimiento son perfectamente visibles con el resto del personal sanitario. En este caso, PAC8 nos plantea un acto de habla directo repleto de oraciones concisas y claras. En primer lugar, abre con un pronombre personal átono proclítico, el cual aparentemente no tiene coherencia en su construcción al tratarse del verbo utilizado (*me viene*). Sin embargo, ese *me* cobra especial importancia porque no apunta su acción al plano morfo-sintáctico, sino más bien al semántico-pragmático: aporta una intencionalidad de gravedad, al señalarse a sí misma en ese momento, desplazando la importancia del demostrativo *aquí*. Tiene un significado de indignación ante lo que está a punto de suceder. Al utilizar al construcción enumerativa *lo primero* añade mayor tensión y nos da pistas de que son varias las circunstancias que causan cierta indignación. Aparentemente lo que ocurre no es de naturaleza conflictiva, pero sí lo que oculta: en lugar de saludarla o realizar algún tipo de introducción cortés, el médico entra al domicilio de PAC8 y "lo primero" que hace es mirar en el cajón donde guarda las medicinas. Algo que actúa como intensificador de gravedad es el argumento que a priori, choca con lo primero que hace (*Él sabe que yo no colecciono… que no soy como muchas que tienen… No, no, no. Yo lo justo.*). Esto entra en conflicto con la

declaración que añade (*y dice, voy a mirar a ver lo que tienes*) y que, sumada a la descortesía de la que hace gala, hace que PAC8 se dé cuenta de la desconfianza que le profesa el médico, previamente establecida por ella: *él sabe*, y sin embargo, mira el cajón. No faltas de gravedad son las declaraciones que le siguen, pues en primer lugar, todas las evocaciones al médico gozan de descortesía (*¿y para qué me llamas?, tú lo que quieres es que te vea, ¿no?, es tontería, si no te puedo mandar medicina porque tienes alergia., No te puedo mandar nada.*). En segundo lugar, se crea una tensión entre ambos en la cual se desprende una discriminación manifiesta, en sus dos vertientes: edadista y sexista. Esto no es nada superfluo, pues mediante el enunciado *¿y para qué me llamas?,* reluce el sentimiento de pérdida de tiempo e inutilidad; *tú lo que quieres es que te vea, ¿no?* ejemplifica una estocada directa a la intencionalidad de PAC8 al llamarlo, poniendo en duda la veracidad y las verdaderas razones por las que lo ha llamado. Es una declaración altamente ilocutiva, y tan ambigua que aquí el modelo de contexto es tan importante como definitorio de la situación comunicativa y la interpretación a la misma que se está llevando a cabo; *es tontería, si no te puedo mandar medicina porque tienes alergia. No te puedo mandar nada,* representa una vez más la desacreditación y falta de escucha activa que caracteriza al profesional médico. El *si* de causalidad aquí establece una relación directa del porqué de su inacción. La manera en que PAC8 finiquita la situación comunicativa (*Digo, ah, pues entonces adiós*) escenifica la tensión experimentada, dejando patente que se encuentra en una encrucijada vulnerable, a merced del despliegue de poder y control ejercido por la figura médica, traspasando los límites del respeto y cometiendo actos discursivos discriminatorios.

3.1.4. ¿Siento que me escuchan cuando hablo o quiero hablar?

(25) [hace un ruido como diciendo "Bueno..."](Risas) [el entrevistador]¿Ni fu ni fa? [la paciente]Ni fu ni fa. Unas veces te escuchan, y otras veces pues... O creen que ven a una mejor, bien, y... (PAC1).

(26) No, ella lo que dice que tiene que atender también a muchas personas. Dice, XXX, que no es usted sola, sino... es otra, otra, otra. Un día dedico a una, otro día dedico a otra (PAC2).

(27) Por supuesto, no creo que no me escuche [la enfermera]. Que todo el mundo escucha, ¿no? Aunque luego digan, mira pues esto es así, es así y se acabó (PAC5).

(28) Ella siempre es la que me atiende. Me pone inyecciones, viene aquí, me toma la tensión, tiene paciencia conmigo... No sé contar de ella, todo lo más bueno que puedo porque es buenísima. Muy cariñosa, me mira como... eso, como hija. Porque yo a veces le digo que si estarán cansados mis hijos de mí ya, porque claro... La edad requiere también muchas cosas, impertinencias y cosas de esas que temo que estén cansados. Dice, no están cansados, XXX. De usted no están cansados, lo que pasa que la vida tiene también... Ellos tienen también sus hijos, su trabajo, dice y no están muy cargados con usted, pero la quieren como madre que es y... Y yo la quiero a ella (PAC6).

(29) Sí, tiendo a ser muy pesada digo, porque los hijos, creo, que se me ha metido en la cabeza que es que soy pesada y que los canso... Y me dice ella... me dice ¡qué va a cansar! Que no, cómo no la van a querer, digo porque no me quieren porque les canso (PAC6).

(30) Y no tengo queja. La única queja que tengo es eso, que tengan que venir

a mí a todo. No que yo antes iba, con mis muletillas… (PAC6).

(31) Porque, aunque no quiera me tiene que escuchar, lo que le diga, ¿no? Y ella viene corriendo y a lo mejor se puede parar, si yo le hablo cualquier cosa la mujer se tiene que parar a escucharme (PAC5).

En (25), la emisión de ruido de PAC1 como forma de respuesta ante la pregunta de si creía que las enfermeras la escuchan, indicó que fue ciertamente incómoda. Tras un silencio de unos dos segundos, PAC1 repitió la respuesta en voz alta del entrevistador, quien respondió a su propia pregunta tras el sonido emitido por PAC1, para confirmar de forma no verbal que no se sentía escuchada. Las palabras entonces quedaron dichas por el entrevistador, eximiendo de responsabilidad a PAC1 por presuponer que las enfermeras deben escucharla. Rescata la expresión del entrevistador para hacer referencia a que no hay una continuidad por parte de las enfermeras en la escucha activa, precedida por unas risas que pretenden descargar del componente conflictivo y descortés de las declaraciones que hará a continuación. El acto de habla viene condicionado por la presuposición de que hay veces que la escuchan, habiendo, pues, otras veces en las que no escuchan. Sin embargo, cuando llega a esta última aseveración conflictiva, no termina el enunciado, virando hacia la razón por la cual cree que no la escuchan (*o creen que ven a una mejor, bien, y…*). PAC1 de esta manera justifica a las enfermeras en su falta de escucha, y termina el acto de habla alargando la conjunción *y*, buscando más razones para justificar y al mismo tiempo, ofreciendo al entrevistador que prosiga con las preguntas.

En (26), PAC2 achaca la problemática de no ser escuchada a la sobrecarga laboral de la enfermera, algo que traslada esta última mediante

la utilización de adverbios de afirmación y cantidad como *también* y *muchas*. Esto se ve reforzado por la declaración que le sigue de la propia enfermera, disfrazada de cortesía mediante el pronombre personal tónico de cortesía *usted*, pero que debido al refuerzo enfático de cantidad mediante el adjetivo *otra* hasta tres veces repetido, cobra una fuerza ilocutiva que parece crear una imagen pública de la paciente como un número más en su cartera de servicios. La declaración tiene cierto aroma catafórico cuando especifica, mediante un paralelismo sintáctico (*Un día dedico a una, otro día dedico a otra)* el esfuerzo que realiza diariamente por desempeñar su trabajo. Este esfuerzo tiene un añadido pragmático de carácter acumulativo, pues mediante el uso de determinados verbos connotativos se presenta públicamente como una profesional entregada a su trabajo ("atender", "dedicar").

En (27), PAC5 comete una incoherencia en su acto de habla al abrir con una locución adverbial de afirmación, para seguidamente utilizar una forma verbal de opinión (no *creo*), la cual niega la certeza anterior. Esta contradicción tiene mayor envergadura cuando da un paso más y declara *que todo el mundo escucha*, aunque con la aparición del marcador del discurso *¿no?*, esa aseveración pierde entidad al apoyarse en una intencionalidad de adquirir aprobación por parte del entrevistador mediante un lenguaje conversacional traducido en un asentimiento, una interjección —ajá, mhm, sí— o un sonido afirmativo que refuerce su hipótesis. Sin embargo, PAC5 se encarga de boicotear su tesis al introducir una concesión aparente mediante la cual en primer lugar, introduce un componente positivo sobre el colectivo enfermero con el propósito de crear una imagen pública no negativa cuando verdaderamente, en segundo lugar,

siga con una declaración negativa con forma subjuntiva, que marca una actitud ideológica que entra en contradicción con la realidad contextual.

En (28), PAC6 identifica ser escuchada con ser atendida. Su intervención se construye a través de una serie de argumentos enumerativos de las virtudes de la profesional de enfermería, donde en ningún momento declara de forma explícita el sentirse escuchada. Por ello, observamos la implicatura de que se siente escuchada al sentirse atendida. Los recursos intensificadores de la figura de la enfermera son variados y representan un escalamiento en la sensación de que es una relación, por parte de la paciente, que va más allá de lo meramente profesional. Esto se ve reflejado en el uso del adverbio temporal *siempre*; de estructuras sintácticas paralelas de acumulación (*me pone…*, *me toma…*); de adjetivos calificativos superlativos (*buenísima*) o de adverbios modificadores de intensidad (*muy* cariñosa); de recursos estilísticos como metáforas (*me mira como hija*). Todo ello, se ve aún más ensalzado cuando utiliza el conector *porque* para introducir ejemplos reales conversacionales con la enfermera, que son el origen de la concepción cognitiva que se esconde tras su vínculo. PAC6 nos da una información valiosísima para entender su modelo contextual: la experiencia con sus propios hijos. PAC6 presupone que sus hijos están cansados de ella, porque presupone que su avanzada edad es una carga para ellos (*yo a veces le digo que si estarán cansados mis hijos de mí ya*). Sin embargo, su modelo cognitivo de envejecimiento —eminentemente negativo— la delata con la utilización de términos en su discurso de connotaciones negativas (La edad requiere también muchas cosas, *impertinencias y cosas de esas que temo que estén cansados*). Este acto de habla perlocutivo generó en la enfermera un sentimiento de compasión que

desencadenó una presuposición para intentar aliviar la pesadumbre de PAC6 (*Ellos tienen también sus hijos, su trabajo*, dice *y no están muy cargados con usted, pero la quieren como madre que es*). De este modo, PAC6 ve en la enfermera la única persona capaz de satisfacerle en el plano de las necesidades físicas (servicios de atención primaria) y de las psicoemocionales (discurso compasivo de la enfermera), por lo que el modelo de contexto conversacional queda blindado positivamente. Volviendo a su modelo cognitivo sobre el envejecimiento, en (29) y (30) sus actos de habla tienen tintes auto discriminatorios (*tiendo a ser muy pesada*; *se me ha metido en la cabeza que es que soy pesada y que los canso*) y están plagados de fuerza perlocutiva sobre la enfermera, creando una respuesta visceral (Y me dice ella… me dice *¡qué va a cansar!*). Esto parece reforzar la idea de que PAC6 retroalimenta su sentimiento de culpa auto impuesta mediante una auto percepción del envejecimiento negativa (*La única queja que tengo es eso, que tengan que venir a mí a todo. No que yo antes iba, con mis muletillas…*), la cual, mediante actos de habla llenos de fuerza ilocutiva, pretende escuchar de la enfermera respuestas complacientes que le hagan sentirse apreciada, vista como una persona válida. La paciente, por tanto, nos brinda una información *sesgada* de la relación enfermera-paciente: no nos habla desde un punto de vista de una paciente, sino desde el de una amiga o, incluso, recurriendo a un término utilizado previamente por la misma PAC6, desde el de una *hija*.

En (31), PAC5 eleva el tono con una perífrasis modal de obligación ("ella me tiene que escuchar"), que va en consonancia con la presuposición cognitiva que realiza: ella, como paciente, tiene el derecho de ser escuchada y la enfermera, como profesional asistencial, el deber de escucharla. Sin

embargo, PAC5 adelanta otra presuposición mediante el uso del subjuntivo sobre la posibilidad de que la profesional no quiera escucharla, y es entonces cuando deja claro dónde está el límite: quiera o no, es un deber que entra dentro de sus competencias. Con la partícula interrogativa *¿no?* no pretende confirmar su declaración anterior, sino hallar complicidad con el entrevistador y beneplácito con respecto a su modelo cognitivo de paciente. Esta argumentación es reforzada al plantear una situación hipotética ("a lo mejor se puede parar"), que resuelve sin miramiento acuñando una vez más la perífrasis modal de obligación, pero esta vez, destacando la razón por la cual debe ser escuchada. Esto es, independientemente de lo que sea ("si yo le hablo cualquier cosa"), y es ahí donde ratifica la escucha como deber y competencia profesional de componente innegociable.

3.1.5. Atención a peticiones extra.

(32) No abuso de nadie ni nada (PAC2).

(33) Claro. Ve que no lo necesito y dirá… (PAC2).

(34) No tengo nada que hacer. No tengo que obligarla a nada (PAC2).

(35) No, porque, te voy a decir una cosa, yo lo comprendo que tienen mucho trabajo y hay muy pocas personas. Su trabajo, date cuenta, que ella no solo da allí, en el despacho, sino luego tiene una casa, otra casa, otra vieja, otra más vieja…(PAC4).

En (32), PAC2, en su acto de habla, transmite la presuposición de que pedir que la enfermera realice alguna actividad extra es un *abuso* de poder desde su posición de paciente frágil. Acompaña como intensificador la construcción *ni de nada*, añadiendo un componente de rotundidad a la aseveración previa. Esto se suma a (34) por el uso de paralelismos

sintácticos y de otro verbo con claras connotaciones de poder (*No tengo nada que* hacer. *No tengo que obligarla* a nada). PAC2, pues, se ve a sí misma en una posición de poder —consciente de su rol de paciente frágil— por el mero hecho de ser receptora de servicios de enfermería. Esto, en lugar de convertirse en un recurso legítimo que pueda aprovechar según su necesidad, se convierte en un recurso auto limitante: PAC2 presupone que las enfermeras no deben adaptarse a sus necesidades individuales, relegando un peldaño más abajo su estado de salud en pos de no interferir con las actividades que la figura de la enfermera realiza de manera sistemática. Por otro lado, en (33), y seguidamente del marcador del discurso *claro*, introduce una presuposición que justifica la causa por la que no recibe un determinado servicio de la enfermera (*Ve que no lo necesito).* Al mismo tiempo, se trata de una aseveración ambigua con fuerza ilocutiva, ya que de no necesitarlo realmente, no dejaría libre a interpretación el final del enunciado con un verbo en futuro, arrastrado por un silencio que deja incompleta la razón por la que la enfermera no ve necesario proporcionar el determinado servicio. De esa manera, PAC2 realiza un ejercicio de aseveración invertida, esto es, declara que no lo necesita a ojos de la enfermera, pero permite entrever que realmente sí que lo necesita, a pesar de no pronunciarlo de manera directa.

Por otro lado, en (35) PAC4 achaca su no intervención ante su posible necesidad extra a la sobrecarga laboral de las enfermeras. Sin embargo, esto parece ser una estrategia discursiva influenciada directamente por una circunstancia adquirida: puede ser, su modelo de evento es una implicación directa de un acto de habla ilocutivo de la enfermera claramente evasivo, ya que la paciente no puede conocer el mundo real de esa enfermera en

particular y su sobrecarga laboral a no ser que esa enfermera le haya hecho mención sobre ello previamente, para evitar llevar a cabo esa petición extra; su modelo de evento es una implicación directa de una presuposición propia, esto es, considera que las enfermeras no tienen tiempo de atender sus necesidades extra. La segunda parte de su intervención está repleta de información, donde la locución verbal *date cuenta* marca una creencia asumida y la direccionalidad de un discurso con esencia catafórica (*que ella no solo da allí*, en el despacho), utilizando un recurso intensificador de frecuencia mediante el uso combinado de una estructura sintáctica paralela más un adjetivo acumulativo (tiene *una casa*, *otra casa*, *otra vieja*, *otra* más *vieja*) y un adverbio comparativo (*más*). Por último, la aparición de un adjetivo calificativo de connotaciones negativas (*vieja*), denota la existencia de una ideología con tintes también negativos sobre el envejecimiento.

3.1.6. Participación en su propio cuidado.

(36) Yo desde luego soy una mujer, no porque yo me quiera poner, poco problemática, ¿sabes? Yo me adapto a… [la situación]. ¿Tú ves? Como ahora. Ahora yo vivo aquí sola, ¿por qué no me he querido ir con mis hijos? Mis hijos están trabajando (PAC3).

(37) Sí, mis hijos me tienen muy vigilada (PAC3).

(38) No es que me protesten ellos ni nada. Que lo que yo digo, voy a hacer esto, voy a hacer lo otro… Ellos no se meten en nada. Pero mis hijos me tienen a mí, hasta la presente, a lo mejor cuando dé lata… Ahora como no doy lata, pues… (risas) (PAC3).

(39) No, porque esta muchacha está muy liada y no puedes decir… ¿Yo qué voy a decir? Si esta muchacha… Tenemos un lío, tenemos un lío… Claro,

ellas vienen todas corriendo (PAC5).

En (36), el acto de habla ilocutivo de PAC3 pretende erigir una imagen pública de agencia y colaborativa, mediante el uso del marcador del discurso modalizador *desde luego* que expresa dicha actitud. Es un recurso discursivo interesante la negación con efecto inverso (*no porque yo me quiera poner*), ya que al explicitar lo que no quiere hacer, precisamente está consiguiendo lo contrario, por lo que la intención de subrayar que es poco problemática logra ese objetivo. Los marcadores discursivos *¿sabes?* y *¿Tú ves?* pretenden mantener la atención intacta y el acuerdo velado con lo que está diciendo por parte del entrevistador, intentando que este la crea. Para esto, recurre a la formulación de una pregunta cuya respuesta no es compartida con el modelo de evento del entrevistador, por lo que la conversación se encuentra en el terreno de PAC3, contestando a su propia pregunta. En este acto de habla, PAC3 deja entrever que su forma de participar no es tanto para con la enfermera, sino para con sus hijos: la implicatura aquí es que participar es igual a no convivir con sus hijos, haciéndonos presuponer que así no molesta, ni entraña una amenaza para el curso vital de cada una de las personas implicadas. Esto a su vez conforma las bases del modelo cognitivo que tiene sobre su momento vital: parece ser que PAC3 se considera poco problemática porque no convive con sus hijos, y no convive con sus hijos porque se considera un problema. Al considerarse un problema, presuponemos que la manera de adaptarse a esa situación es precisamente asumirse como tal y obrar en consecuencia. La causa de considerarse un problema aquí puede ser su estatus de paciente frágil que le lleva a necesitar servicios y cuidados de enfermería que puedan interferir

con la vida diaria de sus hijos. La afirmación en (37) otorga fuerza a esta hipótesis, ya que PAC3 declara que sus hijos la tienen *vigilada*. La construcción del verbo conjugado *tienen* con la partícula intensificadora *me* y el verbo principal conjugado *vigilada*, tiene una clara implicatura pragmática e ideológica: PAC3 considera que sus hijos la ven como una persona dependiente que requiere de una atención exhaustiva, e incluso parece ser, controlada. Sin embargo, ella no realiza ninguna declaración explícita que nos haga interpretar que esté de acuerdo con eso: por ello, la relación de poder entre ella y sus hijos hace que esta se encuentre sometida a un rol pasivo.

En (38), matiza las declaraciones anteriores sobre sentirse vigilada. PAC3, mediante la construcción *No es que* introduce un argumento antiorientado para después, introducir otro que genere contraste con mayor fuerza argumentativa, estableciendo la siguiente explicatura: no solo no le protestan, sino que no se meten en nada. Por otro lado, con la introducción del conector *pero* en el siguiente enunciado, establece una hipótesis inacabada, apelando a la interpretación del entrevistador por medio de una serie de estrategias discursivas estilísticas y conversacionales que maquillan la intencionalidad de sus declaraciones, como el uso de la metáfora (dar la lata) o de la risa. Además de ello, el enunciado ambiguo no guarda unos principios de coherencia semántica, pero que desde el punto de vista de la Teoría de la Pertinencia, no es tan necesaria esa coherencia textual sino una construcción contextual que permita procesar el significado de lo que se está diciendo a través de un acto de habla: en este caso, la presuposición que mientras todo siga como está, la relación con sus hijos permanecerá, hasta que PAC3 entienda que su situación sea problemática —una vez más

aparece sucinta la percepción de considerarse un problema—, en cuyo caso los hijos emprenderán alguna actuación que erradique ese problema o carga.

En (39), PAC5 dinamita la posibilidad de participar en su propio cuidado al identificar la carga laboral de las enfermeras con la razón por la que esa situación no pueda darse. Su intervención es atropellada, inconexa e inacabada, fruto de las veces que el discurso de las enfermeras se ha repetido en base a su experiencia y ha influido en su modelo cognitivo de participación activa en el cuidado: presupone que la única manera de participar pasa por una circunstancia que se escapa a su control, siendo esta la carga laboral de la enfermera que la atienda en el momento o, dicho de otro modo, PAC5 se considera sometida a la oportunidad que un contexto de mayor entidad le permita, o no, desarrollar como paciente. El poder en la relación esta vez transciende la figura de la enfermera, para posarse sobre todo en la figura institucional de la enfermería y su organización.

3.1.7. ¿Dedican las enfermeras el tiempo que creen las pacientes necesario en sus tareas? ¿Desean las pacientes que les dediquen más tiempo del que reciben?

(40) A mí no me molesta. Pero como tampoco no la necesito, si la necesitara pues la llamaría, le diría, XXX, me pasa esto, me pasa lo otro… Porque la muchacha escucha, ¿sabes? (PAC3).

(41) [¿le gustaría que pasara un poquito más de rato?]¡Hombre, claro! Pero como viene con… (Risas) Con la hora, porque de aquí tiene que irse a este lado… (PAC3).

(42) [¿le gustaría que echaran un poquito más de tiempo?]No… Yo sé que

tienen mucho trabajo. Tú sabes que les han cortado ya el servicio (PAC4).

(43) [¿le gustaría que echara más rato?] No, yo no, ¡porque la mujer viene corriendo! Si yo le abro aquella puerta por que no se pare. Que tienes que sacar a otra, luego tiene que irse allí... Dice, es que tenemos hoy de sangre para recoger. Y como viene, ¡oh, oh! Hoy vengo deprisa, anda que no tengo hoy (PAC5).

(44) Nunca me ha dicho que no puedo ir, XXX. No, ella viene. Más tiempo, menos tiempo. Ay, me tengo que ir que tengo mucha prisa, que tengo mucha... Está siempre muy cargada. Y le consulta desde aquí a [nombre del médico] (PAC6).

(45) Ella está muy cargada. Es muy interesada [en el sentido de que se interesa por ella] y a mí no me molesta, al contrario, le veo que... (PAC6).

(46) ...(...)y me acuerdo de mi madre, digo, uy, si esto es como una madre para mí (PAC6).

(47) Sí, a mí no me ha abandonado nunca, nunca (PAC6).

(48) Hombre, yo entiendo que la criatura tiene un trabajo... Mucho trabajo. Y si tiene que atender a varios enfermos... La sangre, los "simtrones", las curas, hacer lo otro... Tampoco no creo que tenga mucho tiempo para que la pares... (PAC33).

En (40), PAC3 establece una relación de necesidad y conformidad. En primer lugar, indica que en el caso de que dedicaran más tiempo, no le molestaría. Luego, introduce la presuposición de que a pesar de no necesitarlo, tampoco es algo que no quiera, ya que en ningún momento ocurre una negación del deseo de recibir más tiempo de atención, sino que

dicha negación aparece cuando introduce el argumento de la necesidad. Profundiza en ese argumento cuando refuerza la disponibilidad de la enfermera al aseverar que esta escucha, por lo que la intencionalidad de PAC3 es de transmitir tranquilidad y confianza sobre la atención que recibe.

En (41), sin embargo, la misma paciente, ante una misma situación hipotética y ante una pregunta diferente, a través de su acto de habla cambia de tono completamente, desequilibrando la balanza entre necesidad y conformidad: aquí predomina un deseo de recibir más atención, pero debido a la carga laboral de la enfermera, ese deseo se ve frustrado. Por ende, su argumentación anterior se ve anulada por esta. PAC3 disfraza su situación de necesidad por la capacidad activa de escucha de la enfermera. Sin embargo, la disponibilidad de la que hacía gala mediante su discurso anterior, difícilmente se hace visible aquí donde la enfermera apenas tiene tiempo de atender a la paciente como esta última desearía. Esta implicatura se ve apoyada por el uso de afirmaciones exclamativas que le dan fuera ilocutiva al mensaje, además de enunciados acabados no por explicaciones, sino por recursos conversacionales como risas, y reutilización de argumentaciones ya usadas por la propia enfermera.

En (42), PAC4 orienta su deseo a una realidad que está fuera de su control. No argumenta el por qué no le gustaría que le dedicaran más tiempo, argumenta la razón por la cual ella presupone que las enfermeras no le dedican ese tiempo. Esta presuposición marca su modelo cognitivo con respecto a este plano de la atención de la enfermera, cuando desplaza hacia el entrevistador esa realidad mediante la construcción discursiva *Tú sabes* y la expresión metafórica *les han cortado ya el servicio*, ambas con gran fuerza ilocutiva. Especial mención se debe hacer a la elección del verbo

cortar, con claras connotaciones ilocutivas, al introducir ahí la implicatura de que es algo no deseado por las enfermeras, por lo que el locus de poder no recae ni en ella ni en las enfermeras, sino en "aquellos que les han cortado el servicio". La relación de poder aquí se traduce en los siguientes escalafones: en primer lugar, los que cortan el servicio o dicho de otro modo, los superiores a las enfermeras, que les impiden tener la oportunidad de emplear más tiempo con las pacientes; en segundo lugar, las enfermeras, que mediante su discurso anulan la posibilidad de revertir esa situación; en tercer y último lugar, la paciente, la cual ve negado doblemente su deseo de recibir más tiempo de atención tanto por el primer nivel como por el segundo.

En (43), no se ve más que amplificado el esqueleto pragmático de (41), con la adición de mayor argumentación discursiva proveniente de las enfermeras, y mayores afirmaciones exclamativas de PAC5, que dotan del discurso de esta última, una mayor entidad y riqueza contextual.

En (44), PAC6 pone de manifiesto una diferenciación en la atención que recibe: el hecho de recibir visita de la enfermera y el hecho de recibir una visita más o menos dilatada en el tiempo. Atendiendo al primer argumento, utiliza enunciados de corta extensión acompañados de fuerza ilocutiva mediante uso de adverbios de temporalidad (*nunca*) o de partículas negativas (*no*). Respecto al segundo argumento, PAC6 no aclara en primera instancia si la enfermera dedica mucho o poco tiempo cuando la atiende, pero a lo largo del desarrollo del mismo, nos permite encontrar la presuposición de que a su juicio, le dedica poco tiempo. A través de la utilización de argumentaciones extraídas directamente de enunciados de la enfermera apelando a la prisa, finaliza declarando que la disponibilidad de

la enfermera es muy reducida. Esto queda reflejado mediante el uso de otro adverbio antónimo del primero, de temporalidad (*siempre*), y el uso de metáforas (*estar cargada*). Esta metáfora cobra fuerza ilocutiva al repetirse en (45), para luego contrabalancear con otro argumento aparentemente incoherente con el anterior. Sin embargo, se trata de un empeño más de PAC6 por exonerar a la enfermera de *su* figura de enfermera, es decir, nos hace presuponer que la profesional que la atiende no solo hace por interesarse por ella, sino que nos hace interpretar que ello cumple más que de sobra sus estándares sobre la atención que cree necesitar. Esto se hace detectable mediante el uso de adverbios intensificadores de cantidad como *muy* y la apostilla introducida por la partícula aditiva *y a mí no me molesta*. El hecho de que su argumentación sea *y a mí no me molesta, al contrario, la veo que…*, la dota de gran fuerza perlocutiva, ya que nos hace sentir que la enfermera llega a casi sobrecoger a PAC6 por el grado de compromiso que esta detecta. Sin embargo, no llega a finalizar su argumentación con alguna prueba de que efectivamente dedique el tiempo que PAC6 necesita: tan solo se trata de una constatación de que la enfermera —a ojos de la paciente— está muy ocupada y que aun así, muestra interés por atenderla. Estas argumentaciones nos transmiten una sensación de conformidad con una circunstancia proclive a la escasez asistencial.

En (46), PAC6 vuelve a recurrir al recurso estilístico metafórico ya apreciado anteriormente en (22), y nos introduce de nuevo la relación simbólica de enfermera/madre-paciente/hija, algo que cobra mayor fuerza ilocutiva y rotundidad en (47) con el uso del verbo conjugado con notorias connotaciones pragmáticas *no me ha abandonado* que, por si fuera poco, se ve intensificado con el adverbio *nunca*, estrategia repetida seguidamente

una vez más. Es por ello por lo que PAC6 parece camuflar bajo su regazo todas aquellas carencias asistenciales que puedan darse, ya sean situacionales o personales, en cuanto a la figura de la enfermera se refiere, conjugando además un sentimiento casi de deuda, de agradecimiento llevado al extremo donde lo que le importa verdaderamente es ser visitada y tenida en cuenta, pero en cuanto se intenta ahondar sobre la calidad/cantidad de los servicios de enfermería, emplea en su discurso estrategias para liberar de dichas carencias en todo caso a la enfermera.

En (48), se dan una serie de mecanismos interesantes que PAC33 utiliza para justificar la falta de atención que recibe, la cual manifiesta de forma sutil. Comienza con una presuposición fomentada por el verbo conjugado *entiendo*, utilizado aquí como verbo de opinión, junto al uso de un recurso metafórico con fuerza ilocutiva. El hecho de utilizar el sustantivo *criatura* le da connotaciones ilocutivas al ser recibido como un sustantivo compasivo, de tintes vulnerables y que otorga poca entidad a la figura enfermera: la implicatura aquí es que la enfermera es tratada como un número más que recibe órdenes, en forma de cartera de clientes, y no puede hacer nada ante una exigencia del sistema que ahoga su deseo de llevar a cabo un trabajo más distendido y comprometido con sus pacientes, a través de la presuposición de que debe tener tal cantidad de trabajo que desencadene lo anterior. Esto se ve reforzado por más argumentos que PAC33 encadena mediante la partícula aditiva *y*. Llegado el momento, la misma PAC33 recurre a una deshumanización de su propia figura de paciente, utilizando de manera coloquial una marca comercial de medicación anticoagulante como sustitutivo de las personas que la reciben (*los "sintromes"*). Este mecanismo discursivo da lugar a dos consecuencias

pragmáticas: por un lado, PAC33, de manera más o menos consciente, es sabedora de la condición numérica de los pacientes a ojos de las enfermeras, justificado por su presuposición de sobrecarga laboral; por otro lado, PAC33 abraza esa concepción numérica al estar incluida en el listado de pacientes o dicho de otro modo, de enfermos, tal y como declara. Finalmente, por si quedara algún resquicio de esperanza, ella misma se encarga de remendarlo con otra presuposición sobre el tiempo del que dispone, siendo demasiado limitado como *para que la pares*. La construcción verbal "parar a alguien" tiene cierta intensidad perlocutiva al percibir esa expresión como acto que requiere algún esfuerzo e incluso interrupción, por parte de quien para a ese alguien, llegando a causar molestia. El que haya utilizado esa última argumentación nos da pistas de su intencionalidad: abre la posibilidad a pensar en parar a la enfermera para solicitar o comunicar algo. Esto se debe a que hay una necesidad insatisfecha, encubierta, que por el ritmo de trabajo de la profesional, no está siendo atendida en realidad.

3.1.8. (Poder) Elegir o no elegir.

(49) *No. Yo no hablo con ella casi. No hablo porque no le da tiempo, porque es que tiene… Es que las personas que vienen así no te da tiempo de hablarles porque las entretienes* (PAC5).

(50) *Con ella le hago muchas preguntas, a lo mejor le hago muchas preguntas y soy pesada, por eso digo que… Lo mismo que a mis hijos soy pesada…* (PAC6).

(51) *No, no. Yo le dejo a hacer. Lo que ella dice. Uy, pues hoy no voy a parar a la tensión. La tensión no le gusta mucho porque como sabe que la tengo alta y me… Hombre, me preocupa… y me sube mucho. Y se ve*

negra para bajarla. Lo que hace muchas veces es no tomármela para no disgustarme, para no preocuparme, pero ella se lo ha tragado (PAC6).

(52) Yo algunas veces por si acaso se le ha olvidado digo, uy, digo… XXX, la tensión. Dice, hoy no, no hace falta, que total tiene usted siempre la misma. No, hoy no vamos a pararnos, hoy no vamos a pararnos. Y eso digo eso es que tengo mucha y lo que no quiere es disgustarme porque, claro, sabe que me preocupo (PAC6)

En (49), en un acto de habla directo, PAC5 eclipsa la oportunidad de elegir desde el mismo momento en que declara no hablar con la enfermera. El uso del adverbio *casi* al final del enunciado destaca como recurso para maquillar la excesiva contundencia de la que haría gala hasta ahora su argumento, algo reforzado por la introducción de la conjunción causal *porque* que acompaña una justificación a la inexistencia comunicativa. Resulta de gran interés el adverbio demostrativo *así*, cuando no antecede ni redondea nada que se mencione antes o después, sino que en su lugar, actúa como partícula perlocutiva al dejar que el entrevistador reciba ese *así* y haga cábalas para interpretar cómo es la enfermera. No obstante, la implicatura gestada a lo largo de la intervención parece indicar que hace referencia a la prisa con la que es atendida, algo que PAC5 también generaliza al hablar de personas y no de enfermeras, aunque se refiera expresamente a este colectivo. La utilización del verbo conjugado *(las) entretienes* conlleva una carga pragmática que destila una sensación de estorbo o incordio, durante el transcurso del ejercicio profesional de la enfermera cuando la visita, por lo que PAC5 se considera, en cierto sentido, un escollo en el caso de que

finalmente lograra hablar con ella.

En (50), PAC6 ubica el hecho de elegir con hacer preguntas, o dicho de otro modo, ella elige hacer preguntas, pudiendo debatirse entre hacerlas o no. Una vez tomada la aparente decisión de hacer preguntas, mediante la locución adverbial de duda *a lo mejor*, deja constancia de una preocupación sobre ser desmedida en el momento de hacerlas. Esto no es algo que necesariamente deba ser así, dado que ocurre una interferencia en el modelo de contexto compartido por los hablantes: la aparición de los hijos. El entrevistador carece de información necesaria como para interpretar con certeza que PAC6 se excede en sus preguntas, tal y como podría hacer con la enfermera ("Lo mismo que a mis hijos soy pesada"). Sin embargo, basándonos en la macroestructura cognitiva que PAC6 ha dejado entrever a lo largo de sus actos de habla, probablemente se trate de un sesgo cognitivo auto-discriminatorio y no tanto de una realidad: PAC6 se considera una carga porque es posible que así se lo hagan creer por medio del discurso de la enfermera y de sus hijos.

En (51), resulta interesante la argumentación que realiza PAC6 desde el punto de vista de elegir o no elegir. Se podría dividir en dos partes claramente diferenciadas. En la primera ("No, no. Yo le dejo a hacer. Lo que ella dice"), PAC6 elige no intervenir, tal y como ella enuncia. Sin embargo, no queda clara la fina línea entre considerarse una elección o no, ya que elegir no elegir, es, en definitiva, no elegir. Se trata en realidad de una ilusión, un espejismo de toma de decisiones donde PAC6 considera que le están dando a elegir cuando en realidad, la enfermera está simplemente desempeñando su función. En la segunda parte, que abarca el resto de sus argumentos, PAC6 demuestra un pacto de silencio no escrito entre la

enfermera y ella, donde la primera concede el deseo de la segunda de no preocuparla por comunicarle el estado de su tensión arterial, hasta el punto de confundir una labor profesional con una labor personal: la enfermera decide no tomar puntualmente los niveles de tensión arterial porque presupone que van a estar altos y a su vez, va a generar preocupación en la paciente. En este sentido, PAC6 hace gala de este ejemplo para ensalzar el compromiso de la enfermera en no disgustarla, y esto se ve reforzado mediante el uso de recursos metafóricos ("y se ve negra para bajarla", "ella se lo ha tragado"), y de paralelismos sintácticos repetidos con gran fuerza ilocutiva ("para no disgustarme, para no preocuparme"). La aparición final del conector *pero* añade un punto aclaratorio y es que, a pesar de que en numerosas ocasiones la enfermera opta por no medir los niveles de tensión, sí que hay veces en que lo hace y no comunica los resultados, guardándose para ella lo que PAC6 entiende por disgusto (los niveles altos). A lo largo de su discurso, se destila cierta relación entre ambas percibida como empática y compasiva, pero al mismo tiempo, carente de igualdad, pues el desbalance en la toma de decisiones es total, ya que la enfermera es quien tiene el poder de tomar o no la tensión, en base a lo que en ese momento le sugiera el estado de la paciente, y no es esta última quien vea ese momento como una oportunidad potencial de elegir que le tomen la tensión, sino más bien como un momento de ofrendar gratitud ante esa decisión de la enfermera, de ahorrarle un mal momento.

En (52), tratándose del mismo momento, PAC6, ante el pacto tácito, hay veces en las que no se siente segura de si se está llevando a cabo, por lo que recurre a interpelar directamente sobre la toma de tensión. Es ahí cuando la enfermera, desde su posición de poder, decide desestimar la

consideración de la paciente, y es que, no se trata de que se le haya olvidado, como supuso PAC6, sino que la enfermera no lo considera necesario porque presupone que los niveles serán altos, como suelen ser según su parecer. No obstante, en esta argumentación encontramos un conflicto más explícito que en (51), donde simplemente era PAC6 quien establecía las relaciones causa-efecto de la toma de tensión. En (52), tenemos un enunciado de gran importancia ("No, hoy no vamos a pararnos, hoy no vamos a pararnos") pronunciado por la profesional que, según el modelo mental de quien lo interprete, puede ser visto de distinta forma. Esto es, PAC6, relaciona que no se detenga a tomar la tensión porque así evita preocuparla. Sin embargo, nos faltaría más información del contexto para achacar esa decisión por parte de la enfermera a esa razón. Teniendo en cuenta la macroestructura, la "telaraña" discursiva que se ha ido desgranando a lo largo de esta aproximación, la variable del tiempo y la sobrecarga laboral planta la semilla de la duda ante esta decisión. El nivel sintáctico en esta argumentación tiene poderosas connotaciones ilocutivas: sustentado por el paralelismo repetido de construcción empleada ("hoy no vamos a pararnos, hoy no vamos a pararnos"), además del verbo (pararse) y sus formas conjugadas que la enfermera elige de manera precisa, utilizando la primera persona del plural para hacer partícipe a la paciente, y así no parecer descortés ante un alternativo "hoy no voy a pararme". Es en este caso cuando desconocemos hasta qué punto pesa más en la balanza de la decisión de no tomar la tensión en la enfermera: la posible falta de tiempo, de interés o sobrecarga laboral; o la empatía y compasión por no encontrar malas noticias y así entristecer el día de la paciente.

3.2. ¿Algo que quiera añadir?

(53) Yo al médico lo molesto muy poco, muy poco, muy poco. Muy poco. Sí. Y muchas veces ni cuando lo necesito porque me aguanto y me "eso". Yo soy poco… Yo veo que la gente va… (PAC3).

(54) Yo nada más que eso, que nos sigan atendiendo bien a las personas mayores porque lo necesitamos. Y eso. Y con cariño, y con… Que veas tú que sí, que se preocupan por ti (PAC33).

Ante la oportunidad de expresarse libremente, en (53), aparece la figura del médico, hacia la cual PAC3 ofrece una visión de respeto y consideración llevado al extremo de priorizar esos sentimientos por encima de su situación de salud-enfermedad. Por un lado, se encarga de destacar como algo positivo que la comunicación con el mismo es mínima, hasta el punto de utilizar estrategias discursivas delatoras de esa sensación de inferioridad, como el empleo de verbos con claras connotaciones ilocutivas (molestar, aguantar). Además, es destacable el uso de paralelismos sintácticos con repetición hasta en tres ocasiones seguidas ("muy poco, muy poco, muy poco"), para luego finiquitar una cuarta vez con la misma construcción, y terminar con la partícula afirmativa discursiva *sí*. Se trata de cinco aseveraciones de que ella no molesta al médico, una detrás de otra. La utilización de adverbios y adjetivos (muy, muchas) de cantidad, como intensificadores de esa aseveración, también articulan el eje sobre el cual pivota la relación de poder. La gravedad de la situación puede pasar desapercibida en una situación comunicativa cualquiera, como un comentario cualquiera, pero desde una perspectiva de desequilibrio de poder, la influencia que ejerce la figura del médico sobre PAC3, hace que

esta se pliegue ante cualquier problema de salud en numerosas ocasiones. El discurso de PAC3 resulta tortuoso en ocasiones y zigzaguea con la utilización de coletillas ("*me "eso""*) o de enunciados inacabados ("Yo soy poco…") que apenas tienen significado desde un punto de vista sintáctico-semántico, pero que en su contraparte pragmática, tiene una intensidad suficiente como para vislumbrar que PAC3 se está posicionando y antecediendo lo que pronunciará a continuación, que no es más que una comparación con esa otra gente que acude a su médico. Llegados a este punto, hay suficiente información amparada por el modelo de evento generado en la situación comunicativa, como para entender que esa comparación hace referencia a ella, alguien que muestra respeto y consideración hacia la figura médica, ilustrada por una inanición; y a esa otra gente que por el contrario, presupone, no atesora los valores que ella sí que tiene, posiblemente causando molestia y pérdida de tiempo al profesional médico. A ojos de PAC3, entonces, su relación de poder con el médico está equilibrada en su realidad, y la que se encuentra desequilibrada es la que compara, a favor de esa otra gente, cuando en todo momento —y a falta de mayor contexto de esas personas aludidas— lo que hacen es ejercer su derecho de ciudadanos a solicitar un servicio de salud.

En (54), de manera explícita, PAC33 declara que se siente bien tratada, y es algo que lleva ocurriendo desde un periodo de tiempo, al utilizar la forma conjugada verbal *sigan atendiendo*. Por otro lado, el uso del pronombre personal átono *nos* da una entidad distinta al acto de habla de la paciente, ya que se considera, en esta ocasión, no ya un individuo, sino un colectivo: ella habla como portavoz de las personas mayores, presuponiendo entonces que a las personas mayores, se les está tratando

bien desde hace tiempo. Además, añade mediante el conector causal *porque* que es algo que todas las personas mayores necesitan. Esto es algo notorio, sobre todo cuando después del marcador del discurso *y eso*, que actúa como puente entre el primer argumento y el segundo, introduce un concepto más además de tratar bien, que es el tratar con cariño. Al mismo tiempo, entremezcla la primera persona del singular con el plural, creando una atmósfera de empatía, ya que devuelve el quid de la cuestión al entrevistador, cuando al mismo tiempo está hablando por sí misma. Hay entonces una ambivalencia del *tú*: PAC33 y el entrevistador. El verbo conjugado en plural aparece de nuevo con *se preocupan*, haciendo referencia a las enfermeras, no ya solo como individuos, sino como entidad profesional. Aquí, en este acto de habla, aparecen diversos actores, siendo PAC33 el canal por el que las personas mayores, las enfermeras, y el entrevistador, transitan. El modelo cognitivo de PAC33 establece a las personas mayores como un bloque vulnerable, que necesita de asistencia que se fundamente en el buen trato y el cariño, y es algo que presupone que el colectivo de enfermería realiza, y que además, se preocupan por dar una buena atención.

2. Hoja de Consentimiento Informado

HOJA DE INFORMACIÓN

Información, Privacidad y Protección de Datos.

Consentimiento Informado.

Gracias por participar en el proyecto de investigación "**COLABORACIÓN TERAPEUTICA EN LA ATENCIÓN COMUNITARIA A PERSONAS MAYORES. UNA APROXIMACIÓN DESDE EL ANÁLISIS CRÍTICO DEL DISCURSO**".

Establecer una relación terapéutica con la persona mayor para construir relaciones de confianza, respeto y empoderamiento en la toma de decisiones y en la participación activa en su cuidado, durante el período que es usuario de atención sanitaria, se convierte en todo un reto. Las ocasiones existen, aunque en muchas ocasiones el derecho a elegir responda más a un proteccionismo legal del profesional que a una verdadera oferta de posibilidades al paciente. Es necesario reconocer cuales son las situaciones en las que las personas mayores desean participar, sensibles a la preferencia y, concretamente, cuales lo son para los profesionales enfermeros. El objetivo de este estudio es el de analizar las relaciones de poder y dominación en la atención sanitaria a personas mayores en el entorno comunitario y diseñar/ desarrollar con los participantes formas de respuesta alternativas.

Se trata de un estudio que utilizará una metodología de tipo cualitativo, enfocado a realizar entrevistas en profundidad a pacientes que se presten a participar y grupos focales a profesionales de la enfermería que den su consentimiento para llevarlo a cabo. Nos gustaría contar con su experiencia profesional con personas mayores, que vivan solas y a las que atiende en su práctica asistencial a domicilio.

Se garantiza el anonimato y la confidencialidad de su intervención, así como de los datos que se recojan.

Podrá ejercitar su derecho a oposición a la participación, rectificación y cancelación de sus datos de acuerdo a la ley Orgánica 15/1999 de 13 de Diciembre (LOPD) de Protección de datos de carácter personal.

3. CONSENTIMIENTO INFORMADO

Título del trabajo: **"COLABORACIÓN TERAPEUTICA EN LA ATENCIÓN COMUNITARIA A PERSONAS MAYORES. UNA APROXIMACIÓN DESDE EL ANÁLISIS CRÍTICO DEL DISCURSO**".

(Nombre del profesional)

- He recibido la hoja de información sobre el estudio
- He podido hacer preguntas sobre el estudio
- He recibido suficiente información sobre el estudio
- He sido informado por (nombre del investigador): _____
- Comprendo que mi participación es voluntaria.

Comprendo que puedo retirarme del estudio:

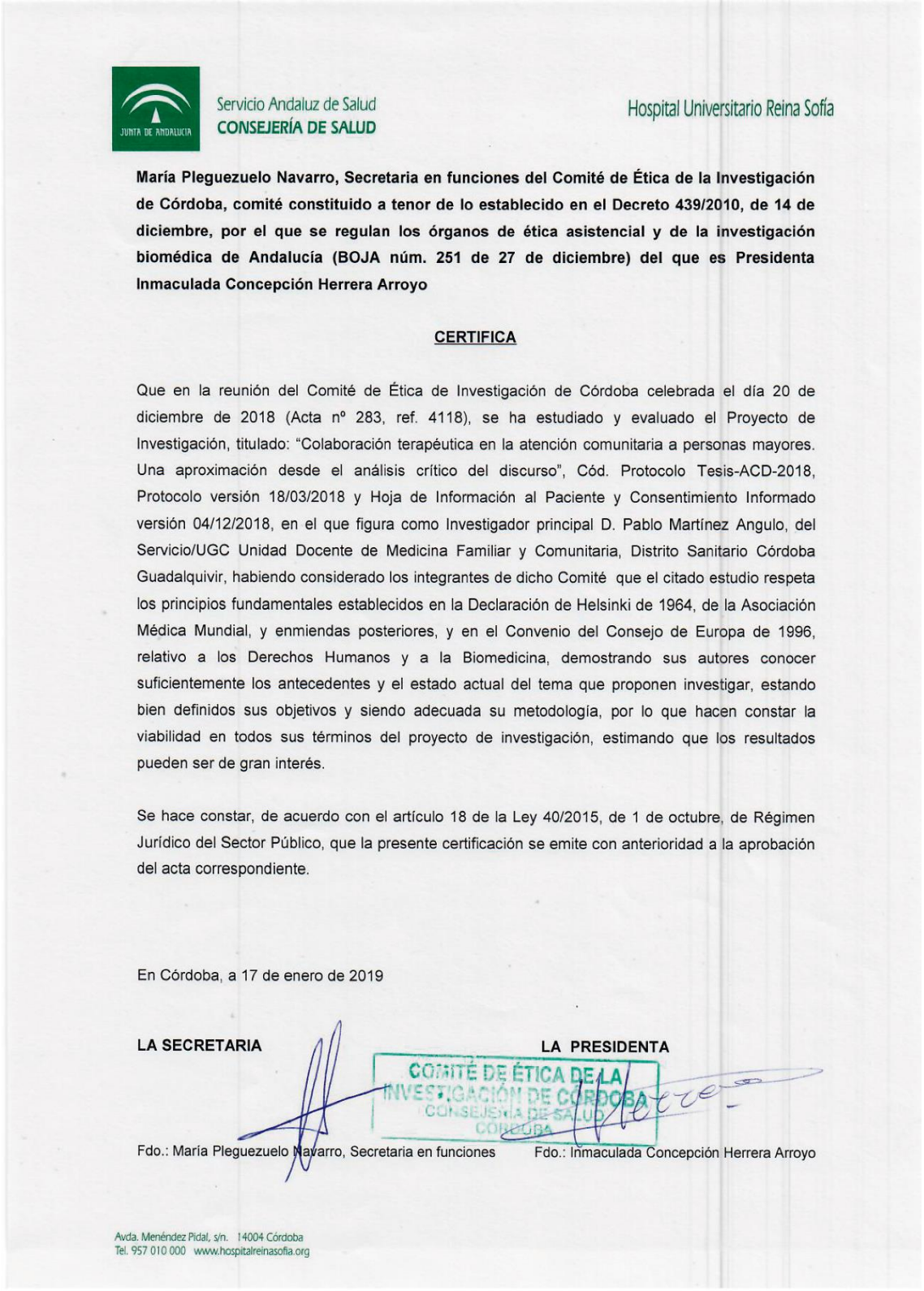
- ✓ Cuando quiera.
- ✓ Sin tener que dar explicaciones.
- ✓ Sin que esto repercuta ni en mí ni mis compañeros.

Expreso por tanto mi conformidad para participar en el estudio.

En _____, a ____ de _____ del _____

Firma del participante **Firma del entrevistador**

4. Dictamen favorable del Comité de Ética – España



Servicio Andaluz de Salud
CONSEJERÍA DE SALUD

Hospital Universitario Reina Sofía

María Pleguezuelo Navarro, Secretaria en funciones del Comité de Ética de la Investigación de Córdoba, comité constituido a tenor de lo establecido en el Decreto 439/2010, de 14 de diciembre, por el que se regulan los órganos de ética asistencial y de la investigación biomédica de Andalucía (BOJA núm. 251 de 27 de diciembre) del que es Presidenta Inmaculada Concepción Herrera Arroyo

CERTIFICA

Que en la reunión del Comité de Ética de Investigación de Córdoba celebrada el día 20 de diciembre de 2018 (Acta nº 283, ref. 4118), se ha estudiado y evaluado el Proyecto de Investigación, titulado: "Colaboración terapéutica en la atención comunitaria a personas mayores. Una aproximación desde el análisis crítico del discurso", Cód. Protocolo Tesis-ACD-2018, Protocolo versión 18/03/2018 y Hoja de Información al Paciente y Consentimiento Informado versión 04/12/2018, en el que figura como Investigador principal D. Pablo Martínez Angulo, del Servicio/UGC Unidad Docente de Medicina Familiar y Comunitaria, Distrito Sanitario Córdoba Guadalquivir, habiendo considerado los integrantes de dicho Comité que el citado estudio respeta los principios fundamentales establecidos en la Declaración de Helsinki de 1964, de la Asociación Médica Mundial, y enmiendas posteriores, y en el Convenio del Consejo de Europa de 1996, relativo a los Derechos Humanos y a la Biomedicina, demostrando sus autores conocer suficientemente los antecedentes y el estado actual del tema que proponen investigar, estando bien definidos sus objetivos y siendo adecuada su metodología, por lo que hacen constar la viabilidad en todos sus términos del proyecto de investigación, estimando que los resultados pueden ser de gran interés.

Se hace constar, de acuerdo con el artículo 18 de la Ley 40/2015, de 1 de octubre, de Régimen Jurídico del Sector Público, que la presente certificación se emite con anterioridad a la aprobación del acta correspondiente.

En Córdoba, a 17 de enero de 2019

LA SECRETARIA **LA PRESIDENTA**

COMITÉ DE ÉTICA DE LA INVESTIGACIÓN DE CÓRDOBA
CONSEJERÍA DE SALUD
CÓRDOBA

Fdo.: María Pleguezuelo Navarro, Secretaria en funciones Fdo.: Inmaculada Concepción Herrera Arroyo

Avda. Menéndez Pidal, s/n. 14004 Córdoba
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Servicio Andaluz de Salud
CONSEJERÍA DE SALUD

Hospital Universitario Reina Sofía

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El Comité de Ética de la Investigación de Córdoba está constituido por los siguientes vocales:

PRESIDENTA
Dña. Inmaculada Concepción Herrera Arroyo. Jefe de Servicio Hematología del HURS
VICEPRESIDENTE
D. José Luis Barranco Quintana. FEA Medicina Preventiva del HURS
SECRETARIA
Dña. María Pleguezuelo Navarro. FEA Digestivo del HURS, Secretaria en funciones
VOCALES
D. Gregorio Jurado Cáliz. Técnico de Función Administrativa. Licenciado en Derecho del HURS
D. Juan Manuel Parras Rejano. Medico de Familia EBAP, Área Sanitaria Norte de Córdoba
D. Eduardo Morán Fernández. FEA Medicina Intensiva H Infanta Margarita de Cabra
D. Javier Caballero Villarraso, FEA Bioquímica Clínica del HURS
Dña. Beatriz García Robredo. Farmacéutica de Atención Primaria del Área Sanitaria Norte
D. Rafael Segura Saint-Gerons. Odontólogo C.S. La Carlota. Distrito Sanitario Guadalquivir
D. Carlos José Pérula de Torres. Enfermero de Familia de Atención Primaria. Distrito Sanitario Córdoba
Dña. Esther Pacheco Rodríguez. FEA Farmacología HURS
D. Pedro José Rodríguez Fernández. FEA Traumatología de la Agencia Pública Empresarial Sanitaria Alto Guadalquivir. Hospital de Montilla.
Dña. Inés Carmen Rodríguez García. Enfermera del HURS
Dña. Sonia García Cabezas. FEA Oncología Radioterápica del HURS
D. Antonio Díaz Valenzuela. Enfermero de la Agencia Pública Empresarial Sanitaria Hospital Alto Guadalquivir. CHARE Puente Genil.
Dña. Eva Mª Rojas Calvo. Auxiliar Administrativo HURS. Licenciada en Derecho
D. Miguel Ángel Romero Moreno. FEA Cardiología del HURS
D. Manuel Jesús Cárdenas Aranzana. Farmacéutico Hospitalario del HURS
D. Félix Igea Arisqueta. Médico de Familia Área Sanitaria Norte de Córdoba
Dña. María Mercedes Gil Campos. FEA Pediatría del HURS

Que dicho Comité está constituido y actúa de acuerdo con la normativa vigente y las directrices de la Conferencia Internacional de Buena Práctica Clínica.

En Córdoba, a 17 de enero de 2019

LA SECRETARIA | **LA PRESIDENTA**

Fdo.: María Pleguezuelo Navarro, Secretaria en funciones | Fdo.: Inmaculada Concepción Herrera Arroyo

Avda. Menéndez Pidal, s/n. 14004 Córdoba
Tel. 957 010 000 www.hospitalreinasofia.org

5.Dictamen favorable del Comité de Ética – Noruega

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst	Ingrid Dønåsen	22845523	20.09.2018	2018/1262 REK sør-øst B
			Deres dato:	**Deres referanse:**
			12.06.2018	

Vår referanse må oppgis ved alle henvendelser

Pablo Martínez Angulo
Ullensaker kommune

2018/1262 Terapeutisk samarbeid i samfunnsomsorgen for eldre mennesker.

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK sør-øst B) i møtet 22.08.2018. Vurderingen er gjort med hjemmel i helseforskningsloven § 10.

Forskningsansvarlig: Ullensaker kommune
Prosjektleder: Pablo Martínez Angulo

Prosjektleders prosjektbeskrivelse
Hovedformålene: - Å analysere maktforhold og dominans i helsevesenet for eldre i samfunnet. - Å planere / utvikle med deltakerne alternative responsformer. Forskningsdesign: Kvalitativ studie styrt av kritisk teori. Omfang: Córdoba-Guadalquivir helseområde, Córdoba, Spania; og Jessheim Vest helseområde, Ullensaker kommune, Akershus, Norge. Begge, primæromsorg-distriktene med urbane og landlige befolkning. Studiemateriell: Personer over 75 år eller mer som bor alene og aksepterer deres deltakelse i prosjektet. Innsamling av informasjon: Dataene vil bli oppnådd gjennom fokusgrupper (FG) og delvis strukturerte intervjuer (DSI). Intervjuene (gruppe eller individ) vil begynne på et ikke-direktiv og svært åpen måte, ved å vedta mer strukturerte former etter hvert som samlingen fortskrider. DSI vil bli utført på steder valgt av deltakerne og FG i et rom av helsesentrene. Under DSI vil deltakerne oppleve erfaringene. Disse erfaringene vil bli delt under FG.

Vurdering
Prosjektet vil gjennom kritisk diskursanalyse analysere maktforhold og dominans i behandlingssituasjonen for eldre som mottar tjenester fra hjemmesykepleien, og sammen med deltakerne utvikle alternative responsformer. Deltakerne skal intervjues om sine opplevelser, tanker og meninger knyttet til behandlingen/tjenestene de mottar. Komiteen vurderer at prosjektet ikke vil fremskaffe direkte kunnskap om helse og sykdom som sådan, og at prosjektet dermed faller utenfor REKs mandat etter helseforskningsloven, jf. Helseforskningsloven § 4, bokstav a.

Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet. Prosjektet kommer inn under de interne regler som gjelder ved forskningsansvarlig virksomhet.

Komiteen gjør oppmerksom på at det faktum at et prosjekt blir vurdert av REK til å være utenfor helseforskningslovens virkeområde ikke er til hinder for at resultater fra prosjektet kan publiseres.

Komiteens beslutning
Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2 og § 4 bokstav a). Det kreves ikke godkjenning fra REK for å gjennomføre prosjektet.

Besøksadresse:
Gullhaugveien 1-3, 0484 Oslo

Telefon: 22845511
E-post: post@helseforskning.etikkom.no
Web: http://helseforskning.etikkom.no/

Klageadgang
REKs vedtak kan påklages, jf. forvaltningslovens § 28 flg. Eventuell klage sendes til REK sør-øst B. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst B, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Komiteens avgjørelse var enstemmig.

Med vennlig hilsen

Ragnhild Emblem
Professor, dr. med.
leder REK sør-øst B

Ingrid Dønåsen
Rådgiver

Kopi til: Tonje.Karine.Brathen@ullensaker.kommune.no