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ARTICLE

Forms of trust and polypharmacy among older adults

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Abstract

This article examines how older adults make decisions about their medications through interconnected axes of trust that operate across social networks. Trust is negotiated by older adults enrolled in a deprescribing programme which guides them through the process of reducing medications to mitigate risks associated with polypharmacy. Habermas' work on the significance of communicative action in negotiating trust within social relationships informs our analysis, specifically in-depth semi-structured interviews with older adults about their medication use and the role of social networks in managing their health. Participants were age 70+ and experiencing polypharmacy. Our analysis discusses the social nature of medication practices and the importance of social networks for older adults' decision-making. Their perspective reflects the critique of late-modern society put forward by Habermas. Negotiating trust in pharmaceutical decision-making requires navigating tensions across and between system networks (health-care professionals) and life-world networks (family and friends). This study contributes to our knowledge of how distinct forms of trust operate in different social spheres, setting the context for the way health-care decisions are made across social networks. Our analysis reinforces the need for older adults to engage meaningfully in health-care decision-making such that a convergence between system-world and life-world structures is encouraged. This would improve deprescribing programmes' efficacy as older adults optimise their medication use and improve overall quality of life.

Keywords: polypharmacy; deprescribing; older adults; social networks; trust

Introduction

You have to trust whoever is making decisions for you. (Study participant)

In 2001, Cohen *et al.* declared medications to be 'socially embedded phenomena' and called for research on the societal significance of medications (Cohen *et al.*, 2001: 441). Such research grows in importance as polypharmacy becomes evermore central to later-life considerations of wellbeing. Many qualitative researchers have answered this call by applying a social lens to this largely biomedicalised

phenomena (Minet *et al.*, 2011; Salt and Peden, 2011; Malvini Redden *et al.*, 2013; Hawkins *et al.*, 2017; Nickman, 2017). This article contributes to this expanding body of qualitative work by examining how older adults make decisions about their medications through diverse axes of trust that operate across social networks. Our study emerges from the move towards deprescribing guidelines and programmes among older adults. Deprescribing involves supervised dose reduction or cessation of medications that are potentially harmful or lack clear benefits (Farrell *et al.*, 2018). As Murphy *et al.* (2008) explain, health-care providers attempt to balance the risks and benefits of multiple medications for their patients. As these risks are particularly burdensome to older adults, scholarly attention must be paid to interventions that diminish the risks of polypharmacy. Deprescribing programmes are one such intervention presently being tested. Participation in a deprescribing programme is a socially embedded activity involving actors from diverse social networks, including the older adult's family members, friends, physicians, nurses, pharmacists, medications and those in the pharmaceutical industry. Participating in deprescribing is also situated in social institutions, primarily the health-care system and the family and kinship systems. As such, when patients are invited to deprescribe, their subsequent decisions are made at the intersection of these dynamic social networks. The forms of trust that are established through these interdependent social networks are central to informing older adults' decisions regarding how they use their medications.

As people enter into later life, the likelihood they will be involved in the health-care system increases. As a result, health-care professionals often become key sources for social interaction. A key component of the ongoing interaction between health-care professionals and older adults is the use and management of prescribed medications. Literature in this area specifically positions medications as objects at the centre of a complex social web. Cheraghi-Sohi *et al.* (2015), for instance, note that the 'medication work' that individuals carry out is supported by social network members (the people considered essential to managing medications). This medication-based work organises and mediates social relationships among members of different embedded social networks. Medications themselves are then positioned as more than objects consumed by humans. They are social actors with the capacity to organise behaviour, foster and mediate social relationships, and even signify and shape the meaning of illness identities.

Medications are also presented as active social agents in that they take on the role of a physician. For instance, 'they bear with them associations to authoritative professionals' (Geest and Whyte, 1989: 345), meaning that they symbolise medical authority. This is similar to the drug-as-doctor metaphor as presented by Britten (1996), suggesting that medications are commonly seen as an extension of the doctor (Britten, 1996). Therefore, if a patient does not want to criticise their doctor, they are unlikely to criticise their medications. In this way, medications have become a symbol of medical authority.

The social networks through which medication work takes place extend beyond medical authority and health-care settings. As Dew *et al.* (2014) point out, the home is in fact the stabilising centre of most medication work. Different medication types exist in this private sphere, as do different sources of knowledge: these compete to align medical knowledge with the household's unique values and practices

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(Dew *et al.*, 2014). The home, as the centre of the social web, 'decentralises' the role and influence of health practitioners to the private sphere (Dew *et al.*, 2014).

Situating medications as socially embedded phenomena is particularly relevant to understanding the experiences of polypharmacy among older adults. The definition of polypharmacy is a topic of debate (Hanlon *et al.*, 1996; Hajjar *et al.*, 2007; Maggiore *et al.*, 2010; Reason *et al.*, 2012; Maher *et al.*, 2014; Alpert and Gatlin, 2015). Despite this, most competing definitions frame polypharmacy as the simultaneous use of many medications. Regardless of which is used, a key point is the considerable risk associated with polypharmacy, particularly for older adults. These risks include escalating health-care costs (individually and system-wide), adverse drugs events, negative drug interactions, non-compliance, cognitive impairment, falls, functional decline, malnourishment and urinary incontinence (Maher *et al.*, 2014). According to the Canadian Deprescribing Network (CaDeN, 2016), deprescribing aims to reduce the burdens associated with polypharmacy in order to maintain and/or improve quality of life. This involves a supervised reduction or stoppage of medications deemed to be harmful or lacking benefit (CaDeN, 2016).

In defining deprescribing, as a key means of responding to polypharmacy, the CaDeN (2016) notes that it is a collaborative process which engages patients, caregivers, health-care teams and policy makers. In this way, deprescribing is a social process and patients' decisions to deprescribe are made with these various networks of support. Therefore, as a way to understand how older adults in Canada make decisions about their medications, it is valuable to understand the diverse sources of trust that operate in these social networks.

Substantial scholarly attention has been paid to the role of trust in health-care encounters (Scambler and Britten, 2001; Goold, 2002; Calnan and Rowe, 2008; Brown, 2009; Brown *et al.*, 2011; Meyer *et al.*, 2012; Meyer and Ward, 2013; Brown and Meyer, 2015; Meyer, 2015; Ward *et al.*, 2015). The work of Brown and Meyer (2015) and Greener (2003) is particularly relevant to the present study in their assertion that coercive trust emerges amidst a dearth of reasonable alternatives offered by health-care providers. Trust is therefore altered based on the presence or absence of choice (Greener, 2003). Trust becomes exceedingly necessary if the older adult placed on a deprescribing plan is vulnerable to future consequences. It could be the case that remaining on certain medications may lead to problematic outcomes; or perhaps discontinuing certain medications that the older adult believes are vital may cause significant uncertainty and stress. In either case, trust is needed in the context of this vulnerability: 'After all, if one is not vulnerable to a future outcome then there is little need to trust' (Brown and Meyer, 2015: 730).

Importantly, Meyer and Ward (2013) clarify dependence and trust; a necessary distinction for this examination of older adults' experiences of polypharmacy and deprescribing. Particularly, in urgent and unfamiliar situations, patients are dependent upon, rather than trust, doctors – the result of temporal constraints (Meyer and Ward, 2013). In other settings, including primary care, in which doctor–patient interactions are not infused with urgency, time and familiarity allow for the emergence of trust (Meyer and Ward, 2013). It is in these settings that interactions hinged around polypharmacy and potential deprescribing occur. Given that

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conversations of this nature are exceedingly more prevalent with older adult patients, it is important to note that although overall trust in doctors has weakened, it has remained strong in older adults (Meyer *et al.*, 2012). Therefore trust – a concept of much examination in medical sociological scholarship – remains an essential concept for further examination in the context of the present study.

Although much theoretical attention has been paid to the role of trust in doctor–patient interactions, Habermas' dichotomising of the life-world and system serves as a valuable instrument to examine issues of trust between doctor and patient (Scambler and Britten, 2001). For this reason, this article will proceed with a very brief overview of Habermas' contributions to our understanding of the emergence of trust in social networks which will ultimately be engaged as a lens through which to consider how older adults make decisions related to their polypharmacy and potential deprescribing.

Communicative action and the formation of trust in social networks

In his theory of communicative action, Jurgen Habermas (1987) problematises the separation of the life-world and the system-world, arguing that in late-modern societies, the former is increasingly colonised by the latter (Gaspar, 1999). The life-world refers to 'the realm of everyday communicative life' while the system-world includes 'government bureaucracy, legal systems and the market economy' (Gaspar, 1999: 408). The operation of relationships in these two distinct worlds diverge. In the life-world, relationships are meaningful in and of themselves and are based on trust formed through intimacy and interdependency. Family and friends are relationships that exist within the life-world, where relationships are ends in themselves. Conversely, relationships are a means to an end in the system-world, where each interaction serves a unique social purpose. The doctor–patient encounter is an example of a system-world relationship: it is based on trust in the doctor's professional expertise and the physician's status within a formal institutional structure. The formation of trust in each social world is a complex process; each form is distinct yet interdependent.

In looking at the relationship between the two systems, Habermas argues that with an increasing reliance on neoliberal market-based logic beginning in the 1980s, the life-world becomes increasingly colonised by the system-world, which threatens the possibility for human solidarity (Habermas, 1987; Gaspar, 1999). With this colonisation, there are fewer open and free avenues for communication. Instead, interactions become distorted so that all exchanges in social networks begin to reflect a purposeful 'means-to-an-end' logic. This process leads to the ultimate elimination of structures of human communication on which the social fabric relies (Habermas, 1987; Gaspar, 1999). The deterioration of these communication structures threatens the development of mutual understanding and, consequently, genuine and trusting relationships between individuals (Habermas, 1987; Gaspar, 1999).

Ideally, the life-world and the system-world would co-exist as they are interdependent; each contributes to social benefit and wellbeing. The system-world would help address the social and material organisation while the life-world would enrich the lives of citizens (Habermas, 1987; Gaspar, 1999). However,

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given the domination of system rationalisation over life-world rationalisation, societies are materially wealthy but lack social enrichment and enchantment (Habermas, 1987; Gaspar, 1999). Gaspar (1999: 408) characterises such enrichment as 'truth, goodness, and beauty'. Without this prosperity in the life-world, communication deteriorates and the human qualities characteristic of our everyday relationships, such as trust, begin to be questioned and eroded (Habermas, 1987; Gaspar, 1999).

The solution is not to destroy the system, as the life-world depends on the accumulating capital in the economic and administrative institutions of the system in order to thrive (Habermas, 1987; Gaspar, 1999). Habermas (1987) further argues that the solution is not in rational-purposive action, as these actions are aligned with a neoliberal market-oriented logic. This logic makes commodities of all things, including the commodification of human relationships. Human communication exists only for utilitarian purposes, disrupting the establishment of genuine human connection and intimacy (Habermas, 1987; Gaspar, 1999).

Given these threats to communicative action and life-world relationships, there is a need to establish an interdependence in human relationships via practical action and critical thought to create space for sincere and open communication (Habermas, 1987; Gaspar, 1999). This space, referred to as the 'ideal speech setting' is a prerequisite for undistorted communication. 'Ideal speech acts' can only exist in these settings and are populated by empowered and free participants (Habermas, 1987; Gaspar, 1999). Dialogue in these settings is essential for debating and addressing issues of social concern in public spheres (Habermas, 1987; Gaspar, 1999). By doing so, the impact of the life-world on the system-world intensifies while the opposite is mitigated (Habermas, 1987; Gaspar, 1999).

In problematising neoliberalism, Habermas is concerned with the growing commodification of human relationships. As the system's colonisation of the life-world continues to expand, this relationship between patient and doctor is commodified. Consequently, purpose that is given a monetary value must permeate the relationship such that the rapport between a doctor and patient exists only for utilitarian purposes. Accordingly, as the system colonises the life-world, the healthy body is commodified and, as a result, some groups have more opportunity to access this commodity than others via the procurement of goods and services necessary to attain and maintain health. The implication of this commodification is that the doctor–patient relationship is re-characterised as a service provider–client relationship. A relationship of this utilitarian nature interferes with the development of genuine human connection.

In managing the health of their changing bodies, older adults rely on their social networks, both in the system-world and life-world. System-world social networks include doctors, nurses, pharmacists, care workers, and so on. The trust that is developed through these relationships is largely based on medical expertise. Although trust of this nature may appear to be sufficient for older adults to make health-care decisions, social networks that exist in the life-world are also characterised by a type of trust that is valuable in this decision-making process. Although the basis of this trust is not medical expertise, trusting relationships with family and friends in the life-world are characterised by a high level of intimacy and personal knowledge.

Methods

The purpose of this project was to understand better how older adults make healthcare decisions through axes of trust that operate across the system-world and life-world. This qualitative study was situated within a larger project on deprescribing as a standard preventative care option for older adults. This larger study was a randomised controlled trial (RCT) which operated as a multi-centre project set in routine primary care. Patients of these routine primary care settings were invited to participate in this study by their primary care physicians. Written informed consent was obtained at that time. Once enrolled in the RCT, participants were randomly assigned to the treatment group (deprescribing programme) or control group (usual standard of care). At enrolment, participants were asked if they were interested in being interviewed about their experiences with medications. If interested, participants were contacted by a research associate to set up a time for interview.

Participants were older adults experiencing polypharmacy, aged 70+, and were patients of the routine primary care centres. Participants who did not speak English were not included in this study because the scales used in the larger TAPER project are validated in English. Similarly, patients with expected mortality within six months were not eligible for participation, as it would be unlikely that they would be available for follow-up for other components of TAPER. Qualitative data collection was conducted at a location of the participants' choosing, which was always in their homes. Of the 40 participants enrolled in the study, 16 consented to and completed the interview: 11 females and five males. The mean age of the participants was 81 years, ranging from 73 to 90. These 16 interviews were deemed adequate in quantity as data saturation was met.

When enrolled in the RCT, baseline data were collected to assess illness, demographics, functional/symptom goals, treatment preferences and perceived medical problems. Based on this baseline information, the pharmacist conducted a medication reconciliation with participants in the intervention group. This process involves the establishment and ongoing maintenance of a list of a patient's medications. This list includes details related to dosage, frequency and administration (Al-Hashar *et al.*, 2017), and is used to ensure consistency in transition points of care and to prevent medication errors and adverse drug events (Sholihat *et al.*, 2018). This list was then used in consultation with the participant and family physician to prioritise medications for possible discontinuation (for participants in the treatment group). Blinding was not feasible or necessary. A total of 40 participants were enrolled in the RCT: 20 in each group. Once the participant was enrolled in the RCT, qualitative data collection for the present study began.

Qualitative data collection continued from December 2016 to October 2017. Of the 16 participants who consented to and completed the interview, eight were from the treatment group and eight were from the control group. In-depth qualitative interviews were conducted with both sets of participants and the average interview was approximately one hour. It is important to note that the objective of these interviews was not to determine differences between the treatment and control groups. Rather, the interviews were engaged as a means to understand better the role of trust in how older adults make decisions related to their medications, regardless of RCT group assignment. These interviews were semi-structured and meant to

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guide, rather than control, the conversation. Interviews evolved in unique ways depending upon how participants responded. This approach ensured the versatility and flexibility of each interview, allowing the participant the space to shape the conversation. Each interview was audio-recorded and transcribed verbatim. Thematic analysis was conducted on interview transcripts using Dedoose software by two coders working collaboratively. This inductive approach was guided by Braun and Clarke's (2006) six-phase method for thematic analysis, which involved organising and reorganising codes into potential themes. Establishing the core of each theme was then necessary, allowing for each to be pieced together in the construction of a larger and coherent story that reflected the findings in their entirety.

Findings

The older adults interviewed for this project demonstrated the very social nature of their medication work. The findings illustrate the way life-world forms of trust are being colonised and eroded by the increasing predominance and reliance on a system-world orientation to medication decision-making among older adults. Further to this, the findings also illustrate resistance to this colonisation that is anchored in forms of trust unique to life-world social relationships. Interpretation of these findings reflects the convergent relationship of the life-world and system-world. This process of colonisation, resistance and convergence gives insight into the medication work that older adults engage in when managing polypharmacy and the possibility of deprescribing.

Colonising the life-world

Participants interviewed in this study consistently articulated the colonisation of their life-world relationships (*e.g.* with family and friends) by their system-world relationships (*e.g.* with doctors and pharmacists). This was evidenced by a reliance upon the system for expert advice regarding health management coupled with the avoidance/dismissal of lay advice from life-world relationships. The expansion of medical authority in the governance of bodies has encouraged this avoidance and dismissal of life-world experience in favour of medical expertise, perhaps simply for peace of mind in medical decisions. One participant, I.P., spoke to this need for peace of mind when asked about how she makes decisions when she encounters a new medical specialist with whom she is unfamiliar. She responded: 'You have to trust whoever is making decisions for you.' The decisions that I.P. is referring to are those made by the system. Here, I.P. has revealed the necessity of trust in the system, and therefore an unquestioned trust in medical authority. Several other participants emphasised this need for trust in the (medical) system. For example, when asked about her feelings towards her medications, W.T. explained, 'I don't think I've ever said no to any med.' As was the case with I.P. above, W.T. demonstrated implicit confidence in decisions made by medical authorities over her body. If a doctor recommends a medication, W.T. sees no need to question or refuse that advice. Accordingly, as the life-world is bracketed by the system, the people who exist in these worlds are encouraged to place trust in medical expertise alone.

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L.C. similarly revealed an inherent faith in his health-care team as a social network: 'Well, I take my medication because my doctor told me to take it … they know more than I do, so I would obey them and take the medication.' Importantly, L.C. has added an element of assumed expertise; he has articulated that his trust in medical authority assumes his doctor knows more than he does. X.M. echoes this expectation: 'I'll just wait and see what [my doctor] says and go with it, whatever she says because I'm assuming that she knows what she's talking about. That's all I can do.' This sentiment, expressed in many of the interviews, is significant because it reveals that many older adults deem trust in the system as necessary, and assume the system holds the most relevant and legitimate knowledge. Ultimately, decisions about one's body are easier to make if one has implicit trust in an authority deemed more knowledgeable, even if accepting this specialised advice comes with some inconveniences. As L.C. explains:

> It's just I'm taking quite a few, seven is quite a few bottles to keep around. They sort of get in the way a bit on the counter, but other than that, it is no problem. If they keep me healthy, I'll just listen to my doctor and keep on taking them.

As a result of this confidence in medical authority, advice provided by relationships operating in the life-world is avoided and dismissed. In some cases, participants reported avoiding discussions relating to their health and medications with friends and families, assuming these people would not be interested. For example, W.T. explained, 'if I was to talk about my meds to an 80-year-old that I see somewhere, I would think that is making me self-centred talking about me and my life.' Here, W.T has revealed that she protects her life-world relationship from talk of medicine in order to be perceived as well-mannered. To share her health issues with life-world friends would be egocentric and perhaps boring. These types of discussions are reserved for system relationships with doctors and other health-care professionals – experts who are trained and compensated to engage in these interactions.

H.S. describes similar feelings, stating that he and his friends 'don't sit around and say "how are you doing with such and such a drug". I don't do that with anybody but my doctor.' In addition to not wanting to be perceived as boring or self-centred, a second inference is that life-world relationships are not characterised by the necessary expertise required for engagement in such discussions. In L.C.'s words, 'I don't talk about it because they don't know. Most people won't know, because they are like me, you know, so I don't talk to them about it. No, I only talk to my druggist or my doctor.' For L.C., neither he nor his friends and family are considered knowledgeable enough to discuss medicine. X.M. reinforces L.C.'s feelings, explaining, 'I would only go to the pharmacist or the original doctor. I wouldn't ask a friend or anything what she thinks.' Perhaps it is common sense that older adults do not view their life-world relationships as sources of trusted medical knowledge, but what is particularly compelling about this finding is that older adults do not appear to confide in their life-world relationships about their hopes, fears, desires, concerns, frustrations and/or successes that are related to their medications. Rather, the majority of talk regarding medication is relegated to the system-world.

As established in these participants' accounts, communicative action, as Habermas defines it, does not (or cannot) exist in the current legitimacy crisis. Communicative action is constituted by open and respectful communication between people in the ongoing hunt for common understanding. As participants explained, they take their medication because their physicians told them to, and they do not question it; it is evident that communicative action does not thrive in the system as it currently exists. Patients are not encouraged to engage in discussions about their prescription medications in order to attain a shared understanding of their health-management plans. This system relationship therefore does not facilitate the formation of ideal speech settings.

This observed colonisation of the life-world by the system is facilitated through human relationships. The system is supported by relationships operating according to specific modes of communication. Medicine as a social institution (system relationships) infiltrates life-world relationships by limiting the extent to which life-world relationships discuss health and the body and influence decision-making. This intrusion shifts the predominant form of trust away from life-world relationships and privileges system-world understanding and expertise.

This is not to say that life-world relationships cannot consist of communication about health and medicine. Analysis of these qualitative interviews reveals that the system has particularly influenced spousal relationships (an example of a life-world relationship) in that medication work constitutes a significant, and occasionally dominant, aspect of marriages between older adults. Most commonly, participants reported that quite often the female partner was responsible for the medication work for both partners (note: all married participants were in heterosexual relationships). For example, M.S. reported that her husband is not aware of her medications, but that she is aware of his and even keeps a book on his health information. Two married participants, P.N. and P.S., were interviewed together and reflected this same observation. According to P.N. (wife): 'I know what he's on and what he should be taking. I don't know if he's so sure about me.' P.S. (husband) confirms this: 'No, I'm not sure about you at all.' In this way, the system's colonisation of these life-world relationships has been facilitated by people's trust in medical authority, which has embedded itself into the fabric of the marital relationship. Couples are not discussing the advantages and disadvantages of their medications, debating the merit of medical opinion or asking one another for advice. Rather, these life-world relationships are reinforcing the system-world's embedded authority. The system exerts dominance in these life-world relationships, particularly through this gendered division of medication labour.

Older adults' resistance

Further analysis of these in-depth interviews found that older adults do resist the erosion of the life-world in their medication work and decision-making. They often spoke of working to establish and sustain life-world forms of trust within their system-world relationships. As X.M. explains, when her doctor invited her to deprescribe, her initial concerns and hesitations were relieved by faith in medical authority:

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> Unless somebody that knows what they're talking about really says you're taking too much of this stuff. And when they cut down the methotrexate I was a little bit disturbed because I was kind of counting on it and I was a little more achy after, you know, taking fewer than three, taking two. And, that bothered me a little bit. But I thought I've got to watch it, if it's affecting your kidneys – that's kind of important. So you just accept that they think it's better for you to take fewer. And just, I have my faith in the medication, the doctors. You just do. (X.M.)

Reinforcement of this trust functions to ensure older adults that following doctors' orders is in their best interest. Interestingly, older adults invest in their relationship with medications a life-world orientation, even if it is to validate and justify their reliance on the medical system.

One of the ways older adults are working to bring the life-world into the system-world is via the development of deep, trusting and personal relationships with their health-care providers. It is not enough that a doctor is a highly trained medical expert; older adults are seeking a highly trained medical expert with whom they have a meaningful and personal relationship. The establishment of life-world relationships in the system signals a response to the loss of communicative action and a disjuncture between the life-world and system-world. In interviews, older adults expressed a desire to bring life-world social relationships into the medical system. For instance, I.P. summarises this kind of work in making decisions about medications:

> I know the people who were recommending different meds and so on at the hospital. I didn't know those people, didn't know their background. They didn't know me. Whereas my cardiologist, I've had her for a number of years. She knows my background. She knows what's happened to me, so I trust her more than some stranger.

Here, I.P. does not question the expertise of the people at the hospital recommending different medications. Rather, she is emphasising that their medical expertise alone is not enough for her to adopt their advice. I.P. is comforted by a personal and long-term relationship with someone who holds relevant medical knowledge, assuring her that the advice given to her is informed by a deep knowledge of her unique history. This account by I.P. illustrates how older adults are trying to create a reliable situation in which two forms of trust converge: a system-world trust based on medical expertise and a life-world trust formed out of their personal relationship with their health-care provider, not as a medical expert but as another caring person in their life.

Another way in which older adults seek to link the life-world and system is by welcoming into their medication work health-care professionals from their life-world social networks. Older adults report dismissing and avoiding conversations about their medications with family and friends. The exception is family and friends who are doctors and nurses themselves, or family and friends who similarly defer to medical expertise for much of their decision-making. For example, although L.O.'s sons are not medical professionals, they are also managing hypertension with medications. According to him, 'When I talk to my sons out in BC [British Columbia] on the phone, it's more about their medications … because they too are dealing with high blood pressure, they'll say, "Dad, what's the

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medication you're on?"' In such cases, the instructions older adults receive from the system permeate life-world relationships with others who have received similar instructions.

In cases where a life-world relationship is with a person who also happens to be a medical professional – which is very common – the emphasis of the relationship shifts to health care. For example, I.P. described her relationship with a friend from her orchestra: 'Well Marg, who play in the orchestra with me … she's nurse background. And I know she aches and pains and arthritis too, just like we commiserate.' For I.P., this relationship provides the combination of a medical expert and a friend with shared aches and pains. These types of life-world interactions indicate older adults' efforts to integrate personal and trusting relationships into the larger system relationships that seek governance over their bodies and health. This effort may be more pronounced in older adults with higher health-care needs and lives more heavily governed by social institutions, such as medicine.

X.M. speaks to this phenomenon in her account of seeking medical advice from a life-world relationship with someone who works in the system:

> I'd maybe ask my daughter if it had anything to do with her line of work, the one in Montreal. You know, in fact I did ask her once about something I was taking, and she said it should be okay for you. She said we get people for dialysis that are a lot worse off. Oh I know, I had a urine test for creatine and they said it was elevated a little bit. And they were stopping – I was taking three methotrexate a week and they put it down to two, and then I was a little bit achy so I asked her. I said, 'should I go back on it?' She said, 'no, just go with what the doctor says'.

As demonstrated in this account, the system and life-world are not divergent entities. All people operate in both the life-world and system-world as either professionals or lay people. Life-world relationships are fostered in the system by older adults and system relationships are fostered in the life-world.

Limitations

Longitudinal approaches would be well-suited in addressing the temporal limitations of this study. Participants were interviewed at one point in time and therefore the findings of this study offer little insight into the lifelong process by which trusting relationships are formed between patients and health-care providers. Further, important future work should investigate how trust is negotiated (or perhaps not) in health-care settings for more diverse and marginalised communities. The homogenous nature of this participant population does not provide adequate insight into the experiences of patients of colour, low-income patients, LGBTQ patients, patients with disabilities and/or recent immigrants. It is reasonable to suggest that the development of trust with system-world actors is a more fraught process for those living at the intersection of these various marginalised communities.

Discussion

The system's infiltration of the life-world is facilitated by human relationships. In order for the system to gain dominance, it relies upon the life-world. Older adults

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demonstrate this reliance in numerous ways, such as avoiding medical conversations with lay people and privileging medical conversation with 'expert' friends and family: an overlap of the life-world and system-world that signals their interdependence. This study found that older adults are hard at work to promote this interdependence. The promotion of this integration, Habermas argues, might lead to the creation of ideal speech settings, which are necessary for ideal speech acts (Habermas, 1987; Gaspar, 1999). In Gaspar's (1999: 410) words, the absence of these settings may be due to 'constraints that prohibit the actors from speaking up freely, [the actors] do not share the same presuppositions and assumptions, and there is a lack of consensus on the values that help to define the collective goals'. These are the prerequisites for communicative action. Older adults' efforts to form lifeworld-type relationships with the system's actors (*e.g.* doctors, nurses and pharmacists) demonstrates their efforts to create these preconditions.

These efforts to establish interdependence between the life-world and system are supported by Ballantyne *et al.* (2011) in their work describing older adults as active agents in the management of their medications. Ballantyne *et al.* (2011: 181) found that older adults' 'health-related dispositions and actions are informed, but not defined, by biomedical culture'. Rather, participants demonstrated efforts to create a hybrid patient culture in which their life experiences are blended with conventional and alternative approaches to health (Ballantyne *et al.*, 2011). These efforts establish older adults' resistance to system colonisation by way of merging the considerations of both worlds.

The system in disguise: patient-centred care

Patient-centred care has gained popularity in many health systems (Moody *et al.*, 2018). The key components of this model involve the partnering of health-care providers with patients and families in the provision of care that is individualised and best for the patient (Moody *et al.*, 2018). According to Kolind and Hesse (2017), a patient-centred approach involves identifying and emphasising the outcomes the patient desires and the ongoing and active engagement in discussions regarding treatment goals. An admirable aim, it is nonetheless important to consider the ways in which this approach, promoted within the system, has donned a life-world mask.

Patient-centred care appears, at first glance, to be part of the life-world. It is, however, designed by, advocated for and administered within the system. The system-driven practice of patient-centredness is therefore tested when the patient/family introduces something from the life-world that is not system-oriented. For patient-centred care to be truly patient-centred, the desires of the patient (and family) must be prioritised above those of the system. This is especially true for patients who are invited to deprescribe in response to their polypharmacy. Despite biomedical support for deprescribing, a patient-centred approach should involve the collaboration of the life-world and system – the patient (and family) and health-care team – in this decision-making process. To support older adults holistically in a 'patient-centred' manner, medical practitioners ought to be cognisant of the different axes of trust through which older adults make decisions about medications, specifically deprescribing. Medical practitioners should be aware of

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and receptive to the ways in which older adults promote this collaboration of the life-world and system-world. Doing so will hopefully create opportunities for forms of true and authentic communication that are not distorted.

These findings are consistent with the work of Barry *et al.* (2001) which draws upon doctor and patient interviews to demonstrate that patients receive better care when doctors are sensitised to patients' life-world concerns. Barry *et al.* (2001) note that structural reform is necessary to offer an appropriate environment for doctors to engage in this type of lifeworld-sensitised care. Doing so will involve doctors reframing their understanding of quality care from technological considerations towards 'their patients feeling understood, listened to and treated like whole and unique human beings (Barry *et al.*, 2001: 504).

Restoring communicative action

Older adults are managing decisions about their health across the axes of trust in two interdependent social networks: the system and life-world. This conceptual framework allows us to map deprescribing decisions that older adults make along these different lines of trust. Habermas views communicative action as communication between people to address differences and arrive at a shared understanding (Frank, 2015). Frank (2015) observes its breakdown in the medical system, where life-world communicative action has been excluded by the system's communication. For health-care providers implementing deprescribing programmes, there must be a willingness to restore communicative action in medicine: this means medical professionals should spend time with patients/families in pursuit of a common understanding of what is best for the patient (Frank, 2015). According to Frank (2015), this ongoing process provides opportunity for society to reinforce value-commitments and increase trust and legitimacy among social institutions.

The findings of this study offer important contributions to our knowledge of how distinct forms of trust operate in different social spheres and influence health-care decisions. Practically, this study reinforces the call for active patient engagement in decisions relating to their bodies and their health. In the study by Brody *et al.* (1989), patient attitudes towards illness and recovery were correlated with their perceived involvement in their health-care decisions. Patients who felt they were actively involved in their health care had less discomfort, fewer illness-related concerns, greater feelings of control over their illness, increased satisfaction with their physicians, greater symptom alleviation and an improvement in their medical conditions (Brody *et al.*, 1989). These findings are well supported in the literature. For example, Greene and Hibbard (2012) highlight the untapped potential of patient engagement (or activation) in improving health outcomes and call for interventions to support this engagement. Accordingly, more patient and family involvement in health-care decisions – which is to say, greater validation of the life-world within the system – improves patient outcomes.

To conclude, the commodification of human relationships (such as the doctor–patient relationship) by way of the system's colonisation of the life-world holds important, contemporary implications for practitioners implementing deprescribing programmes. The re-characterisation of the doctor–patient relationship as a

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service provider–client relationship obstructs the establishment of authentic human connection. If the commodification of health care is to continue, and thus the commodification of the healthy body, we will witness further threats to communicative action. For deprescribing programmes to optimise medication use and improve older adults' overall quality of life, communicative action in the medical system needs to be established and maintained.

This study has found that one way in which this is occurring is through the efforts of older adults in their construction of lifeworld-type relationships, characterised by trust, in the health-care arena. Considerable scholarly work has previously examined the operation of trust in health-care encounters, maintaining that trust is necessary amidst uncertainty, vulnerability (Brown and Meyer, 2015) and particularly for older adults (Meyer *et al*., 2012). When studied against the backdrop of polypharmacy and deprescribing, trust remains an essential ingredient in the health-care needs of the older adults of this study. Through a Habermasian lens, it is evident that by way of resisting life-world colonisation, polypharmaceuticalised older adults are reserving space for trusting and authentic human connection in traditionally system-dominated territory.

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