SSM - Qualitative Research in Health 7 (2025) 100509

Contents lists available at ScienceDirect

SSM - Qualitative Research in Health

journal homepage: www.journals.elsevier.com/ssm-qualitative-research-in-health

Accomplishing organizational compassion in critical care settings: An artifact analysis of the visitors' book agency

Letizia Caronia [a,*], Federica Ranzani [a], Arturo Chieregato [b]

[a] University of Bologna, Department of Education Studies, Via Filippo Re, 6, 40123, Bologna, Italy
[b] Niguarda Hospital, Piazza Ospedale Maggiore, 3, Milano, 20162, Italy

ARTICLE INFO

Keywords:
artifact analysis
Critical care settings
Organizational compassion
Patient and family-centered care
Sociomateriality
Ventriloquism
visitors' book

ABSTRACT

Hospitalization in Intensive Care Unit (ICU) is a dramatic disruption of the taken-for-granted flow of everyday life for the patient's family members. Especially in the case of long-stay hospitalization, the emotional and physical burden makes them "secondary patients". As the recent "compassion turn" in healthcare normatively maintains, the staff's individual communicative competences are crucial for providing empathic and compassionate forms of care, oriented to the ecology of family life. However, personal skills and interpersonal communication cannot alone fulfill the requirements of compassion-oriented patient- and family-centered care. A question arises as to how to move from individual-based compassion toward a compassionate healthcare environment. Which organizational conditions, artifact-based supports can foster taking care of the patient's relatives' suffering? Drawing on scholarship on sociomaterality, this paper reports findings from a corpus-based study on a narrative-care practice implemented in three Italian ICUs: the visitors' book (VB). Integrating artifact analysis and texts analysis, we illustrate how VB accomplishes organizational compassion, therefore ventriloquizing the ward's orientation toward it. We advance that adopting VB in an ICU can be a way to enact context-based, situated and distributed compassion-oriented family-centered care, which can complement forms of care relying on individual attitudes and interpersonal communication skills.

1. Introduction

Beyond the critical conditions that determine admission to an Intensive Care Unit (ICU), undergoing critical care is acknowledged as a traumatic experience as such, not only for inpatients but for their relatives as well (Davidson et al., 2012; Engström & Söderberg, 2004). Invasive therapies such as mechanical ventilation, pain, co-morbidities associated with hospital stay, risk of sepsis, anxiety, sedation, withdrawal and awakening, impact on patients (Jackson et al., 2010) and family members (McAdam & Puntillo, 2009) often implying long-term effects analogous to post-traumatic disease, for both (Jones et al., 2004). These conditions are fully described in literature and known respectively as Post-Intensive Care Syndrome (PICS) and Post-Intensive Care Syndrome-Family (PICS-F) (Azoulay et al., 2005; Davidson et al., 2012; Huggins et al., 2016). Relatives, in particular, have to manage not only the trauma related to witnessing the here-and-now critical conditions and fight for survival of the inpatient family member, but also anxiety related to the compromised quality of life and permanent disabilities most ICU patients have to live with as a consequence of the increasing rate of survival to critical illness (Davidson, 2009). The consequences of such a burden (e.g., depression, anxiety, and other post-traumatic syndrome symptoms) can be so serious that relatives can be considered as "secondary patients" (Reinhard et al., 2008). Since family members are often the primary caregivers of discharged patients, taking care of them, understanding and responding to the needs associated with their experience of ICU and preventing unsuitable consequences represent more than an ethical issue as it impacts patient care efficacy, safety and quality of life. As research has demonstrated, family members' needs are of psychological and relational nature, and mostly consist in talking about the "disruption in the life-world" they experience (Engman, 2019; Maynard, 2003), engaging in making sense of it, and sharing their pain with a compassionate interlocutor (Azoulay et al., 2001; Bijttebier et al., 2001; Davidson, 2009). Recognizing and taking care of these needs and relatives' lived experience of ICU is part of an ecological approach to critical care, also known as "patient and family-centered care" (PFCC) (Conway et al., 2006). The staff's individual communicative competences, attitudes and orientation toward the normative call to empathy and compassionate care (see Department

* Corresponding author.
E-mail addresses: letizia.caronia@unibo.it (L. Caronia), federica.ranzani2@unibo.it (F. Ranzani), arturo.chieregato@ospedaleniguarda.it (A. Chieregato).

https://doi.org/10.1016/j.ssmqr.2024.100509
Received 14 October 2024; Accepted 8 December 2024
Available online 9 December 2024

of Health, 2013; Williams, 2017) are certainly crucial for providing forms of (critical) care oriented to the ecology of family life (Gooding et al., 2011; Way & Tracy, 2012). However, the burden of providing PFCC can be overwhelming for professionals working in healthcare contexts as demanding as hospices and critical care wards, where care is extremely intensive as well as particularly "emotionally challenging and physically draining" (Simpson et al., 2020, p. 340). Beyond relying on the staff's individual attitudes and commutative skills, how can a ward accomplish inpatients' relatives' caretaking as a collective? What organizational conditions, artifact-based supports can foster care toward patients' relatives' suffering? What is needed to move from individual-based compassion toward compassionate healthcare environments?

Drawing on scholarship on sociomateriality, this paper reports results from a multisite corpus-based study on an innovative narrative-based care practice adopted in three Italian ICUs. It consists in equipping the visitors' waiting room with a book where visitors - mainly the patients' relatives - can leave written traces of their experience. Informed by the medical humanities' emphasis on the healing properties of non-medical artifacts and practices, the visitors' book (VB) has been designed by the hospitals' management as a practical implementation of guidelines fostering the PFCC.

2. Organizational compassion: the new frontier of patient and family-centered care

The rise of the "Patient-Centered Approach" (PCA) as the golden standard of care established the necessity to involve patients as active participants in their healing process and include them in decision-making processes (Castro et al., 2016; Mead & Bower, 2000) as a means to acknowledge patients' rights of autonomy and self-determination, but also and primarily as a means to maximize patients' satisfaction, therapeutic compliance, and chances of healing (Greenfield et al., 1988; Kaplan et al., 1989). Facing phenomena such as population aging and the increase in chronic conditions, the PCA has recently been reformulated in terms of "patient and *family*-centered care" (Conway et al., 2006; Davidson, 2009; Davidson et al., 2017). The relevance of such an approach is particularly evident in critical care. Especially in cases of long-stay hospitalization and long-term rehabilitation, a patient's condition has long-term consequences and leads to more or less permanent forms of cognitive and/or physical impairments which families have to deal with in their daily lives. Two main elements concur to display the orientation of a ward toward PFCC: interpersonal communication and the socio-material dimension of the ward. "Good" communication between healthcare providers, patients, and families is widely acknowledged as playing a pivotal role in facing "biographical disruption" (Bury, 1982; Engman, 2019) and building a therapeutic alliance based on mutual trust and adherence to therapies (Epstein & Street, 2007; Mauksch et al., 2008; Stewart, 1995). By narrowing the definition of PFCC as a communicative and relational way to take into account and respond to their non-medical needs, PFCC converges with the contemporary "compassion turn" in nursing and healthcare work (Abrams et al., 2024; McAllum et al., 2023).

Although scholars define compassion in different ways (see Blomberg et al., 2016; Dewar et al., 2013; Perez-Bret et al., 2016; Shea et al., 2014), they converge in recognizing that compassion is a social emotion (Nussbaum, 1996) "in that it is inherently other-regarding" and "it implies that the object of one's compassion is experiencing some sort of pain or suffering" (Kanov et al., 2004, p. 814). Further, it is less a state of mind than a process consisting of different and sequentially organized components: noticing/recognizing the other person's suffering, feeling/connecting/relating to that person and, typically, (re)acting/-responding to the other's pain (Kanov et al., 2004; Way & Tracy, 2012). (Re)acting/responding, i.e., doing something to take care of or otherwise reduce the person's pain, is the specific sub-process that differentiates "compassion" from similar constructs such as empathy, sympathy and caregiving (Avramchuk et al., 2013). Engaging in compassionate care is, therefore, quite an emotionally and behaviorally demanding task. Notwithstanding, compassionate care is increasingly recognized as a "hallmark of quality care" (Sinclair et al., 2016, p. 193; Williams, 2017) and a moral imperative for care work (De Zulueta, 2013, 2015): professionals are increasingly requested to deploy deeds to "decrease the others' pain and sufferings" and "provide comfort for patients and their family" (Tehranineshat et al., 2019, p. 548).

As it has been stressed, this pressure on professionals for "compassionate care" as if it were a matter of an individual's attitude and practices is both simplistic and counterproductive (Crawford et al., 2014). It is simplistic since it underestimates the clinical context and organizational dimensions as if compassion were an individual's intrinsic quality not informed by systemic structures, organizational processes and contingencies (e.g., time constraints, production-line approach to care, turn-over) that foster or hinder compassionate care; it is counterproductive as it risks producing disengagement since delivering compassionate care can be perceived as an umpteenth burden by professionals who often experience their work as a never-ending and hyper demanding task (Barnes, 2018). Consequently, and as Way and Tracy maintain (2012), individual-based pressure for compassionate care risks producing rather than reducing transition "from empathy and investment to emotional exhaustion, depersonalization, and alienation" (p. 295). Clearly enough then, personal skills and interpersonal communication alone cannot fulfill the requirements of compassion-oriented PFCC, at least within complex organization-like contexts, such as critical care wards. Building on organizational research and a long-standing tradition of studies on sociomateriality in workplace settings, scholars started investigating the implementation of what is known as "organizational compassion" (Kanov et al., 2004). Scholarship defines Organizational Compassion (OC) as the set of social and material ways through which a healthcare context communicates and accomplishes compassion, i.e., *noticing, empathizing, and responding* to suffering (Kanov et al., 2004, see also the recognizing, relating and (re)acting model, Way & Tracy, 2012). According to this perspective, compassion should not be conceived of as individual cognition, feelings and delivered acts, but as structured organizational practices taking charge of, and responding to suffering (Dutton et al., 2014; Frost, 1999; Frost et al., 2000, 2006; Kanov et al., 2004; McAllum et al., 2023). OC is thus more than the sum of aggregated individual practitioners' compassionate behavior (Madden et al., 2012) as it involves an ongoing, collective and systemic capacity of a) communicating the ward's orientation to compassion and b) accomplishing it in and through recognizable and ostensible practical courses of action. With its emphasis on the health care context's routines, policies, architecture and artifacts, OC is therefore an overall design of care (Crawford et al., 2014) aimed at overcoming the limits of individual-based pressure for compassionate care (McAllum et al., 2023; Pestian et al., 2023).

OC has been investigated as a crucial dimension of workplaces and an "ought to be" component of organizational life aimed at recognizing and coping with distress (Frost et al., 2006; Miller, 2007). Not surprisingly, particular emphasis has been given to healthcare settings (e.g., hospice, Way & Tracy, 2012; acute mental health care, Crawford et al., 2013; palliative care, Sinclair et al., 2017) where practicing compassion appears to be particularly relevant, if not the core component of the practitioners' everyday work.

Despite the noticeable number of studies and policies concerning OC in diverse healthcare contexts, research overlooks *family*-oriented OC in ICUs where *noticing, empathizing, and responding* to suffering cannot but concern also (if not mainly) the patients' relatives. Indeed, while attention has been paid to implementing and studying the impact of *patient*-oriented tools (typically ICU patient's diaries, see among others Bäckman & Walther, 2001; Griffiths and Jones, 2001; Mickelson et al., 2021; Phillips, 2011; Roulin et al., 2007), artifacts designed for taking care of *relatives'* ICU related traumatic experience have been rarely implemented and investigated (but see Di Gangi et al., 2013). Filling this

gap, this study reports the findings on an innovative project aimed at introducing a narrative-based artifact designed for ICU patients' relatives: the visitors' book (VB). The overall research question leading the study was understanding if and to what extent this artifact-based innovation of the ward aligned with the requirement of contemporary pressure for PFCC in ICU and met the requirements of OC.

3. The agency of artifacts in (healthcare) contexts

Arguing for the constitutive entanglement of the social and the material in organizations' everyday life, research on artifacts in institutional settings and workplaces (Streeck et al., 2011) and the sociomateriality approach to organizations (Cooren, 2004; Cooren et al., 2012; Harré, 2002; Leonardi et al., 2012; Orlikowski, 2007) set the premises for studying the role of things in social contexts, namely: sense-making is distributed on and accomplished by different participants whether they are human or non-human entities; artifacts are just as "context-shaping and context-renewing" (Heritage, 1984, p. 242) as human communicative actions are; meaning and culture are inscribed in things' affordances (i.e., features that indicate or suggest possibilities for action, Gibson, 1977, 1979; Hutchby, 2001; Norman, 1988) and projected functions (Caronia, 2019). Within this theoretical framework, artifacts are conceived of as having agency, i.e., the competence to make a difference (Cooren, 2008, 2012): through their presence, affordances and choreography, they state principles, values, and professional requirements, contribute to constituting a moral order, channel individuals' behaviour and define their local identities. In a few words, they are conceived of as enacting a constraining, eliciting, enabling and behavior-shepherding role.

In line with these theoretical premises, artifact analysis pays attention to objects' affordances, location, and juxtaposition to other objects and is aimed at accounting for what objects do in a given context (i.e., performativity), what and how they communicate (i.e., topicality), to whom (i.e., addressivity) and on behalf of whom they communicate (i.e., ventriloquism, Cooren, 2010). A consistent bulk of sociomateriality-informed research addressed artifacts in healthcare settings, underlying the performative force of things such as: hospital beds (Strauss et al., 1985); the dentist's chair (Marsciani, 1999); digital clinical records system (Bruni, 2005); glove boxes, monitors and handwritten clinical records (Caronia & Mortari, 2015); paper-based documents (Brummans, 2007; Sterponi et al., 2017, 2019); or ICT and e-libraries (Nicolini, 2007). Despite this interest, there is a lack of sociomateriality-informed studies on the role the so-called guests' or visitors' books has in hospital wards.

Mostly studied in public places such as museums or memorial sites (Noy, 2015, 2020), the visitors' book is a specific kind of textual artifact whose agency depends on both its mere "being there" as an empty text waiting to be written, and the sequence of texts actually handwritten by the visitors. Once located in an institutional public place, VB presence communicates the institutional willingness to open up an intersubjective space where the voices of clients are welcomed, legitimated and valued. Irrespectively of what may be written and how, this artifact is a welcoming device that contributes to defining the relationship between the institution and its clients. Further, VB location, implicitly yet inferably, defines the boundaries of what the clients' voices are expected to be about (i.e., the local experience on site) and who are the main addressees of the visitors' written texts, namely: the staff and the other visitors who can access and read the written texts. The artifact's affordances and location, therefore, channel the visitors' behavior as they suggest and make a specific course of action relevant (communicating via handwriting), topicalize communication, and delineate its intended addressees.

Contributing to research on the performative strength and communicative density of VB in public places, we assume that, and empirically show how, introducing it in critical care settings as an allegedly family-centered care tool appears to be a practice dense of meanings and implications that are not yet fully investigated.

4. Settings, corpus and methodology of the study

The VB project was designed by the management of three Italian ICUs as a practical implementation of guidelines fostering PFCC. ICUC1 is located in a public hospital in a small northeastern Italian town working as a hub center for over one million people. It primarily handles neurosurgical and trauma patients. Data were collected from 2010 to 2022. ICUM2 is in a metropolitan general hospital in a highly populated town in northern Italy. It predominantly admits acute adults and pediatric neurocritical patients for trauma, neurosurgical emergencies as well as highly specialized elective surgery. Data were collected from 2016 to 2022. ICUF3 is a neurocritical care unit and post-elective orthopedic surgery ICU in a university hospital in central Italy; data were collected from 2013 to 2015. The three ICUs adopted similar policies as to the relationship with the patients' relatives: the daily conferences were undertaken by the same doctor and nurse in a private and dedicated room; the conferences were scheduled at a specified time, yet also tailored to the visitors' needs; unrestricted access to the patients' room; and psychologically supported access for children.

The project consisted in placing a guest book-like artifact in the visitors' waiting room. Relatives were not requested to fill it in, nor were there any instructions, indirect prompts or encouragement: leaving a written trace or not, of what kind, length, style, addressed to whom, and to what purposes were entirely the relatives' decisions.

Given the specific features of this textual artifact, VB has been submitted to both an artifact analysis and a textual analysis of the written entries. The artifact analysis took into consideration VB's location, its juxtaposition to other objects, as well as the following affordances: format, dimensions and texture. Data of artifact analysis were integrated with the peritextual,[1] semantic, pragmatic and rhetoric analysis of the naturalistically gathered texts (N = 1115, 38 of which written by patients). Texts were given an ID, transcribed verbatim, and processed through NVIVO14. They were coded according to the metadata available: ICU, textual genre (letter to the patient, drawing, diary-like entry, photos, postcards), age and writer-patient relationship (when declared), word number, and peritextual features such as explicit addressee, data, signature(s), opening and closing formula, notes. Texts were subdivided into meaning-based units of analysis (UA). UA has been defined as the minimal semantic unit irrespective of its morphological or linguistic features (word-sized or elliptical units of analysis such as "good luck" were counted as one UA, like complete sentence-formatted units, such as "you are so kind"). UA were analyzed according to a semiotic-informed thematic analysis (see Braun & Clarke, 2006; Charmaz, 2006; Guest et al., 2012) along three dimensions: semantics (what is said, i.e., the propositional content of an utterance-in-cotext[2]); pragmatics (what action is accomplished through the utterance-in-cotext), and rhetoric (i.e., how what is said is said). Semantic, pragmatic and rethoric themes, subthemes and category-related codes were applied by two independent coders. Codes were mutually exclusive within each dimension; if more than one semantic, pragmatic, or rhetoric code were applicable, coders decided for the dominant one (k 0.9). For the purposes of this paper, we integrate findings from the artifact analysis and the analysis of the texts' peritext, addressivity, and semantic "references to ICU experience".

The research project was developed in accordance with Italian law n. 196/2003 and EU Regulation n. 2016/679 (GDPR 2016/679), which

[1] "Peritext" is a textual analysis category which refers to and encompasses all the components surrounding the main text, such as title, subtitles, acknowledgment, table of contents, forewords, afterwords (see Genette, 1997).

[2] Cotext is the textual analysis category which refers to the portion of the text surrounding a given semantic unit. It is therefore different from "context", indicating the utterances' extratextual socio-cultural circumstances (Genette, 1997).

regulates the handling of personal and sensitive data. Approval was obtained from the Ethical Committee of the project's leading hospital. All participants provided written informed consent prior to enrollment in the study. All names and details allowing for identification have been fictionalized.

5. The visitors' book in the ICU: the artifact's location and affordances analysis

In the three ICUs where data have been collected, VB was positioned in the visitors' room (see Fig. 1).

Although the wards' visiting policies are tailored to visitors' needs as much as possible, patients' relatives still spend a consistent bulk of their time in the visitors' room: when waiting to enter the patient's room, when some medical procedures occur at the patient's bed and they have to leave the room, or when they wait to meet the staff. It is in this room that they mainly meet the family members of other inpatients. The room as such is therefore and mainly a "waiting" room where no specific activity is at stake: given the highly critical conditions of their hospitalized relatives, it is reasonable to anticipate that this empty place can be imbued with the feelings mostly associated with the patient's relatives' experience: anxiety and distress.

The presence of VB in this place is meaningful firstly when compared to its absence. It equips the place with something to do and makes it relevant to read other visitors' written texts and write down the visitors' thoughts. In doing so, its mere presence tells something about the ward or, as the ventriloquial perspective would frame it (Cooren, 2010, 2012), speaking *through* VB the ward defines itself as a place where the visitors' voice counts. Also, consider the actual location vs. alternative places where VB could have been located, e.g., in the patients' room. Its location in a collective place gives the written texts a public destiny that inferably channels topics (i.e., what visitors will write about) and addressees (i.e., to whom they write).

VB dimensions and format also contribute to defining the artifact's agency. In the three ICUs, VB were quite large, making it almost impossible not to see them: VB dimensions amplified its welcoming function and implied action, namely inviting to read and write. Further, the large size suggested a rather unlimited length for the texts and made those previously written amply visible for the next authors. In doing so, VB projected relevance to visitors' writings as well as their being part of a collective text. As for the format, it is worth noting that VB provides a sequential structure for the texts that cannot but follow one another (vs. for instance posting them on a wall). This structure transforms each writing into a co-text dependent, co-text renewing entry: the meaning, function and even existence of any written text is channeled by what has been written before and affects what will be written afterwards (on the impact of page format on the text, see Gitelman, 2015; Goodwin, 2007). By virtue of its format, VB defines writings as intersubjectively constructed, intersubjectively destinated.

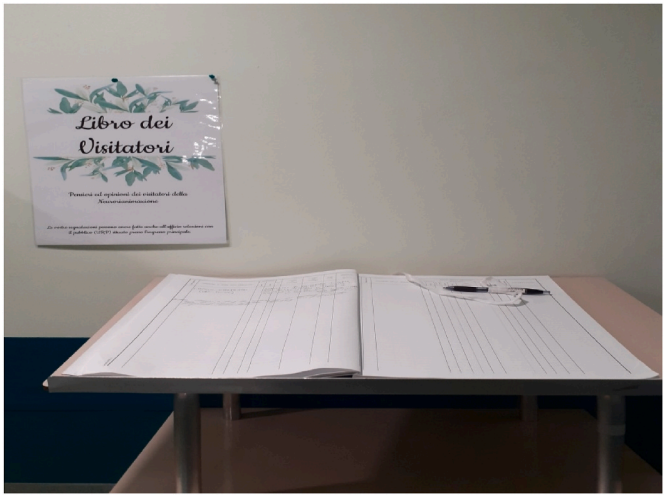

Fig. 1. The visitors' book in ICUM2.

Two other features contribute to defining VB agency: VB's juxtaposition to the available pen and the paper texture. They both stage handwriting as the preferred modality. Often overlooked, handwriting is a major sense-making feature (Noy, 2020): it contributes to creating a sense of authenticity and, when connected to the often co-occurring date and signature (see below), handwriting also contributes to establishing a sense of uniqueness of both the text and its author. Providing texts with a "fresh" aura which recalls talk (Goffman, 1981), handwriting is indeed perceived as the most embodied written communicative modality (Hull, 2003), a distinctive and barely inimitable mark of the Self, defining the text as an authentic carrier of the author's thoughts, opinions and wills. As Goffman (1981) would have it, the author, the principal and the animator of the message conflate in a unique endorsing voice. However, VB handwritten texts are available for public reading and scrutiny: they are neither private letters nor are they publicly available yet anonymous texts. Providing texts with an oxymoron-like quality, VB confers a public, accessible, and traceable quality to handwritten and therefore, hyper-personal texts. As Noy (2020) had it, handwriting in VB makes a public record of what is unseen (e.g., thoughts, lived experiences). Via the materiality of the paper and the permanent quality of VB, written texts become archeological tracks of the individual submitted to public scrutiny and sense-making. Publicly displayed, the handwritten texts are concurrently framed as highly personal and "made to occupy the public sphere" (p. 1325). However, there is more than this.

Handwriting is culturally recognized as implying taking a first-person perspective and a commitment to authenticity and accountability. In a few words, the large size of the page and paper-pen system frame already written and incoming messages as sharable, first-person-written, fresh, and credible tracks of the authors' voice. The artifact's location and affordances suggest that it works as a "talking object" conveying identifiable meanings: family members' voices count and can take whatever space they need; the displayed visitors' voices are authentic and reliable; their narratives are shared and preserved in a common space; there is a recipient for such a unique, personal and embodied voice which, inferably, is the staff who located the artifact and other relatives living in the same temporarily shared life-world.

From an artifact analysis viewpoint, VB is allegedly a space of asynchronous intersubjectivity (i.e., not constituted in co-presence, either spatial or temporal)[3] opened up in-between the authors (mainly the patients' relatives) and their readers, i.e., the staff and the other visitors. The wards that adopted this artifact can be conceived of as speaking through it: by introducing VB in their space, they stage themselves as oriented to taking care not only and unmarkedly of the patients, but rather and markedly of their relatives as well. Still, the meanings and the functions embedded in an artifact's affordances and location as well as the courses of action it makes relevant are actualized (or not) by its users. A question arises as to whether the visitors align with what VB makes relevant, to what extent and how. To address these questions, we analyzed the peritextual cues of the VB texts, their addressivity and references to the ICU experience.

6. Textual analysis

6.1. Peritextual features: the genre, epistemic and identity work of signature and date

Visitors' written texts (N = 1077) were analyzed according to their

[3] We want to thank the anonymous reviewer who suggested the construct "asynchronous intersubjectivty", which perfectly renders the phenomenon the VB appears to create.

peritextual features. A subcomponent of paratext (Genette, 1997), the peritext is the set of peripheral, liminal communicative devices (e.g., cover, titles, table of contents, forwards, notes) that connects the text with its audience, frames it as belonging to a particular genre and "ensure[s] for the text a destiny consistent with the author's purpose" (p. 407). As maintained by semiotic scholarship (Eco, 1979; Zinna, 2011), written texts' peritextual features accomplish fundamental pragmatic functions as they index the intended audience, stage the author's displayed identity and provide interpretive cues for the reader. The emerging peritextual features in the VB corpus were: signature(s), date, opening and closing formula, and location. Table 1 reports the distribution of peritextual elements in the VB corpus.

As Table 1 shows, signature and date are the most recurrent peritextual elements. Three out of four texts have at least one signature and close to two out of three have a date in addition to the signature, and one-third has a closing formula through which the author adds some kind of ritual closing. Opening formulas are mostly references to explicit addressees. Opening and closing formulas contribute to the pragmatic work of the text as they are ways for establishing and maintaining (types of) relationship with the addressee.

Signature and data, respectively, mark authorship and provide the text with a specific temporal location. In doing so, these textual components perform genre, epistemic and identity work. They identify the text as "testimony", i.e., the (written) report of a first-person lived experience which credibility stands on two discourse pillars: the presence of (spatio)temporal details and being framed as first-hand information (Heritage, 2012; Jacquemet, 1996; Pomerantz, 1980). Since "place" is structurally given by the location of the VB, authors add details on the "when" and "by whom" of the information that enhance its epistemic accuracy, veracity and sincerity. In particular, signature recurrence in the corpus indexes the importance attributed to leaving a personal and therefore unique trace of having been there: as Noy (2015) maintains, "the ritual of signing is a way of 'doing attendance'" (p. 79). The person who is speaking through the VB exploits its affordances that make it relevant (and in some sense culturally expected) to mark statements as "one's own". Furthermore, this mark of authenticity attests the authors' intention of making oneself recognizable as a specific identifiable person whether visitors signed in italics (two out of three times) or in capital letters to ensure readability (one out of three times). As for the date, although it can be seen as an unmarked component of many forms of institutional communication, its "non-required" nature in VB makes it work as a marked element: definite temporal location contributes to the work of performing the author's identifiability as well as the epistemic accuracy and therefore the veracity of what the text is about.

Along with handwriting (see above), signature and date contribute to accomplishing "identity work": countering the "routine case" perspective ordinarily at stake in institutions (Heritage, 2004), visitors appear to stage their experience as idiosyncratic and therefore publicly take a stance toward the "tension between the organizational perspective that treats the individual as a 'routine case' and the client for whom the case is personal and unique" (p. 237).

6.2. *The recipients of the VB's texts: opening formula and explicit addressivity*

Close to 11% of the texts were introduced by an opening formula that mainly addressed the intended recipient of the text. Examples of VB opening formula are: "Hi docs"; "Hi to the nurses and doctors of the ward", "To my dad", "To all the staff of the ICU". Although not so frequent, still the opening formula, when present, designed the staff as the recipient two out of three times.

As this peritextual feature appeared to differentiate the social use of VB from other narrative-based care tools such as ICU diaries (Bäckman & Walther, 2001; Griffiths and Jones, 2001; Mickelson et al., 2021; Phillips, 2011; Roulin et al., 2007), we crosschecked this data with data from the analysis of the explicit addressivity *in* the texts. By paying attention to the use of personal pronouns, verbal forms as well as lexical items, we coded explicit addressivity toward the patient or the staff as present or absent. These categories were meant to differentiate texts where the author intentionally designated a specific addressee and summoned an identifiable intended reader vs. texts that appeared to be written to and for a generic reader (e.g., "we are grateful for what has been done for us"). The presence vs. absence of explicit addressivity is indeed a textual cue of the meaning and functions attributed to VB: while the absence of explicit addressivity frames the text as a mere "track of presence", an entextualized sign of having been there (Park & Bucholtz, 2009; Silverstein, 2019), the presence of explicit addressivity frames the text as a recipient-designed message, a means to talk to a specific someone.

The NIVIVO-assisted textual analysis confirmed data from peritext analysis: 80% of the VB texts deploy explicit addressivity; 65% of them are addressed to the staff, 33% to the patient, 1.5 % to a religious entity and 0.5% to other recipients, such as other visitors. The following are examples of texts explicitly designed as addressing the staff.

Ex.1 ID55ICUF2
[Date]
With the (???*) sincerity, we thank **you** for the superior standard of care that **your** team provided for our dear father. **Thank you** for supporting us through the most unfortunate and painful time. We will never forget **your** level of (???), kindness and patience during this time. Thank **you**, R. family from CANADA" (English in original).
[*unreadable]

Ex. 2 ID114ICUM3
[Date]
We arrived November the 2nd at N. hospital, desperate. Dr DM and Dr R. worked a miracle saving Maria. Then we spent twenty days in ICU experiencing what professionalism and sensitivity are. **You** always supported us with deeds and words. Thanksgiving is not enough, we wish we could hug each of **you** not only to say thanks but to check if under **your** uniforms there were ever a pair of angel wings. Thank **you** for all **you have done** and still do with profound love. We will never forget **you**.
(Signed in capital letters by three authors with name and family name).

Differently from findings in previous studies (see Di Gangi et al., 2014), VB appears to be interpreted by patients' relatives more as a means to enter into dialogue with the nurses and doctors who are or have been taking care of their loved ones than as a tool to establish a communicative bond with their inpatient relative. Along with the textual marks of the author's identity (i.e., signature and handwriting), the explicit selection of the staff as the intended recipient frames VB as a dialogic space, an invitation to engage in a simulacrum of conversation between embodied, specific, recognizable and non-standardizable family members and, two out of three times, the ICU staff. In addition to what family members write about (see below), authorship and addressivity cues strongly suggest that family members align and comply with what the artifact's location and affordances project: its being as a tool for establishing a state of (asynchronous) intersubjectivity.

6.3. *Writing about ICU experience: VB as a compassion tool*

According to the NVIVO-assisted thematic analysis, right after the staff's professional expertise and relational competences, the third most recurring theme in the corpus is the ICU lived experience.[4] Unexpectedly, 98% of references to the "ICU lived experience" concern the

[4] The two most recurring themes were the staff's professional (17.8% of the semantically coded UA) and relational (17.0%) competences. The frequency of references to the ICU lived experience was 15.6%.

Table 1
Peritextual features.

CORPUS	Signature		Date		Closing Formula		Opening Formula		Place	
Texts (N = 1077)	807	75.4%	651	60.4%	360	33.4%	115	10.7%	14	1.3%

visitors' experience. Without any doubt, the entextualized traumatic experience is not so much the one lived by the patient, but the one lived by relatives. Qualitatively portrayed as a dramatic disruption of their life-world (Maynard, 2003), the family member's ICU experience is vividly described through a plethora of rhetoric formulas: by recurring to hyperbole and ineffability, the authors communicate the overwhelming nature of what they are experiencing. Here are some examples of these textualized first-hand testimonies and "extreme-case formulations" (Pomerantz, 1986) of how disruptive the ICU experience can be for patients' relatives.

Ex. 3 ID28_ICUC1
First of all, I thank God for having allowed my mother to survive through your intervention. I thank you, all the doctors and nurses that are taking care of her; for you, her name is Maria Passi, for us, she is just Arie. This is the most dramatic moment of my life. I never imagined that something so serious could happen to my mum, the "unbreakable". Finally I can see her very beautiful eyes, but I miss her smile. I hope I can see it soon. I will continue trusting in God, the doctor of doctors, for her optimal recovery, so that she can live with us and her four grandchildren. Thank you again. Glory to God.
(Signed, name, capital letters)

Ex. 4 ID8_ICUF2
Until a few days ago, we were living what we call a "normal" life and now we are here. We were living an intense life and now we are living an "intensive" life. We wish to thank from the bottom of our hearts the staff, the surgeons, doctors, and nurses for their professionalism, but most of all their kindness and warmth, because it is only through Love that the world can be saved. God bless you
(Signed in italics, name and family name)

Ex. 5 ID4_ICUF2
I wish to thank …. it is impossible to find the right words to be able to display the immense and deep gratitude toward people that perform their work every day with professionalism, dedication, patience, love and comprehension toward those that are submitted to them. All that while never, and I say never, leaving us without your support, the right words at the right moment, and that smile which comforts you, making you feel protected, and exhorts you to never give up. This is what happened to my son, rushed here from S. with an extremely fine thread of hope, sensing the abyss, and since then, living in a dimension that doesn't belong to you anymore and that devastates you. It is as if oxygen is missing, air, life […]. Now, what I've written is nothing but a reductive way that doesn't allow me to express the feelings, sensations and emotions that have been crowding my head. But there is something which I'm absolutely aware of: the certainty of having had all you close to me […]. Thank you from the bottom of my heart to the doctor, the "Human Being", dear Dr. B.
(No signature)

Ex. 6 ID214ICUM3
This experience changed my life forever! To all the doctors and nurses I want to say: you are extraordinary people, you emit incredible energy and warmth that help the patients and their relatives in these very difficult moments. Thank you from the bottom of the heart for all you have done, may God bless you. […] Acceptance and unconditional love are words that bring hope and a lot of light
(Signed in italics: name, family name, plus reference to the relationship with the patient, i.e. "the wife of patient R. V.")

As the examples above illustrate, when they come to talk about the ICU experience, family members vividly portray it as a dramatic disruption of *their* everyday life, a deep, almost indescribable lived experience of suffering, loss of hope and disorientation made affordable thanks to the staff's professional and relational competences. Not surprisingly and consistently with findings from the artifact analysis (see above), most texts are autobiographical narratives. According to the narrative medicine claim on the healing properties of autobiography (Charon, 2007), VB agency appears to consist primarily (although not exclusively) in providing such form of self-care: it stages itself and is naturally used (i.e., not elicited by the researcher nor the staff) as a place for writing about and therefore transforming a blurred biographical event into a bounded, shaped and therefore tractable and communicable experience.

Crossing data from texts' semantic analysis and addressivity analysis, a major finding emerges: not only does VB appear to promote and legitimate the communication and sharing of the phenomenological breakdown lived by relatives as the consequence of the ICU hospitalization of a family member, but it is also used to disclose this overwhelming experience to the staff. In a few words, the analysis suggests that a) family members delegate the function of carrying their lived experience to VB, and b) rely on it to disclose their more intimate thoughts and feelings as if it were a compassionate listener acting on behalf of the staff. Consistently and as the examples above illustrate, gratifying and thanking the staff are the most recurrent discursive activities accomplished through VB texts (43% and 33% respectively, of the pragmatic units of analysis).

7. Discussion: the agency of VB

The recent family-centered turn and normative pressure toward compassion in health care settings make it relevant to investigate how a critical care setting can respond to both requirements as an organization, i.e., through tools and practices that go beyond individuals' attitudes, relational competences and goodwill. Integrating artifact analysis and textual analysis of a corpus of visitors' written texts (N = 1077), in this paper we analyzed the meanings and functions of the visitors' book, a narrative-based care tool implemented in three ICUs as a way to tangibly deploy the ward's orientation toward taking care of inpatients' relatives' experience.

Artifact analysis. Building on the premises of artifact analysis, we showed how VB location and affordances project the ward's willingness to take into account and value the visitors' voice, making it sharable while safeguarding its uniqueness. In particular.

a) the artifact's presence on site appears to work as a prompting device accomplishing the first pair part of an interaction that makes it relevant for the visitors to reply and engage in a simulacrum of dialogue, mainly with the staff (on the dialogicity of written texts, see Calaresu, 2022; Eco, 1979).
b) the artifact's suggested modality, handwriting, strongly contributes to framing VB as a stage for delivering first-hand experiences, vivid testimonies whose credibility stands on their being embodied traces of the self.

Textual analysis. Showing how texts' signature and date accomplish genre, epistemic, and identity work, the analysis of peritext attests that the visitors actualize the artifact's projected functions. Visitors seem to appropriate VB as a means for telling, displaying and sharing what they index as their *own* unique, non-standardizable and authentic testimony written by a recognizable "I". In doing so, visitors meet and align with what VB's affordances tell about the ward: being a place where the

patients' relatives' individual voices matter and are taken into account.

Results concerning addressivity and the textualization of ICU experience strongly differentiate the use of VB from the use of other narrative-based care tools, namely ICU diaries. Although reported as beneficial for patients' relatives as well (Johansson et al., 2015, 2017; Mickelson et al., 2021), ICU diaries are conceived of as narrative-based tools *for the patients* in that they are written by nurses or relatives to construct and provide them with a memoir of their stay in ICU. VB, on the contrary, appears to be interpreted by the authors as a communicative space where they can speak of *their* ICU lived experience and address this disclosure to the staff. In short, data from artifact analysis and (peri)textual analysis corroborate each other and concur in showing that VB is both intended and appropriated as a family care device whereby visitors a) build a bond and establish a state of (asynchronous) intersubjectivity with the staff, b) disclose their experience, c) narrate their suffering, and d) state their case as unique, strongly distancing their perspective from the usual "routine case" perspective typically at stake in organizations. If we consider that family members' ICU-related needs are reported as mostly consisting in making sense of the phenomenological disruption they experience and disclosing their pain to a compassionate interlocutor, these needs appear to be responded to by VB.

8. VB as an organizational compassion device: concluding remarks

As recent research on OC in health care suggests, delivering efficient as well as compassionate care cannot rely only on the professionals' individual goodwill and interpersonal communication skills, at least within complex organizations, such as critical care wards. Therefore, a typical organizational issue arises as to how a ward can accomplish inpatients' relatives' caretaking as a collective, i.e., beyond the staff's individual attitudes and commutative skills. Building on OC main assumption, namely that a ward's orientation to compassionate care can be enacted by and inscribed not only in the professionals' communicative canons but also in the routines, policies, architecture and artifacts that "speak for" the organization (Cooren, 2012), our study empirically illustrated that the visitors' book can work as an OC device. We showed that this textual artifact both ventriloquizes the ward's orientation to taking into account and responding to the patient's relatives' suffering, and accomplishes OC care. Overcoming the constraints and characteristics of many forms of institutional communication (*omissis*, techniques for anonymization, data aggregation), VB does what other forms of information gathering used in hospital wards (e.g., client's opinions or satisfaction survey) cannot do: it provides a place for, and therefore responds to the need to tell, display and share one's own lived ICU experience. By providing a (perceived as) safe space for disclosing ICU lived experiences and embracing its narrative, VB accomplishes "noticing and responding to suffering" which are two necessary conditions of compassionate care. Therefore and following Cooren's perspective on artifacts' agency in organizations (2004, 2008), we make a case of VB making a difference in the environment according to its location and specific affordances: when it is deployed, organizational compassion is not only talked into being (Heritage, 1984) in the ICU but also "performed into being".

However, it is in and through VB's *actual* use by visitors that the third condition of OC, i.e., acting, is brought into being. By showing that visitors comply with VB agency, our study attests that the entanglement between the VB social and material dimensions works: it is the sociomaterial hybrid entity constituted by the artifact and its users that ultimately accomplishes OC and realizes the ward's orientation toward this new frontier of PFCC.

8.1. Limitations of the study and implications for policies and practices

This study presents some limitations, mostly related to its naturalistic design. Given the *post hoc*, naturally occurring quality of the data, we did not collect nor access any systematic information on the authors and their inpatients' relatives. Therefore, no stratification of the corpus according to demographics and/or the patient's status, length of stay and outcome was possible, nor was any correlational analysis. While the multisite design overcomes the major limits of single-site studies, sociocultural differences between the three ICUs in terms of the clients' and staff's (professional) culture haven't been taken into account. Another limitation concerns the nature of the artifact and its impact on the discursive genres collected. It is more than reasonable to assume that VB's affordances make it not the most suited outlet for expressing dissatisfaction or critiques.

Further research is needed to corroborate these findings on a larger scale and to take into account the linguistic and cultural differences of ICU patients and relatives. Beyond variation of the language used to fill in VB, it is reasonable to assume that VB healing functions are strictly connected to the visitors' cultural representations of writing in public places, as well as their familiarity with this communicative modality.

According to our study, VB both communicates the wards' orientation toward compassionate care and works as a device to accomplish it. Therefore, wards adopting this innovative and relatively costless communicative tool can stage themselves as organizations that are not deaf to the patients' relatives' ICU experience, but rather know that family members' needs are at stake, making them relevant and legitimate, and responding to them.

CRediT authorship contribution statement

Letizia Caronia: Conceptualization, Data curation, Formal analysis, Project administration, Supervision, Writing – original draft, Writing – review & editing. **Federica Ranzani:** Data curation, Project administration, Resources, Supervision. **Arturo Chieregato:** Data curation, Formal analysis, Methodology, Writing – review & editing.

Fundings

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

We thank Dr. Laila Portolani (AUSL Romagna, Italy) and Dr. Luca Bucciardini (Neurocritical care, AOU Careggi, Florence, Italy) who supported the project in their intensive care units. We would also like to thank Giulia Benericetti and Carla Scattolini for their insights on the project.

References

Abrams, R., Conolly, A., Rowland, E., Harris, R., Kent, B., Kelly, D., & Maben, J. (2024). Self, interpersonal and organisational acts of compassion amongst nurses during times of acute stress: A qualitative analysis. *SSM-Qualitative Research in Health, 5*, Article 100437. https://doi.org/10.1016/j.ssmqr.2024.100437

Avramchuk, A. S., Manning, M. R., & Carpino, R. A. (2013). Compassion for a change: A review of research and theory. *Research in Organisational Change and Development, 21*, 201–232. https://doi.org/10.1108/S0897-3016(2013)0000021010

Azoulay, E., Pochard, F., Chevret, S., Lemaire, F., Mokhtari, M., Le Gall, J. R., Dhainaut, F., & Schlemmer, B. (2001). Meeting the needs of intensive care unit patient families: A multicenter study. *American Journal of Respiratory and Critical Care Medicine, 163*(1), 135–139. https://doi.org/10.1164/ajrccm.163.1.2005117

Azoulay, E., Pochard, F., Kentish-Barnes, N., Chevret, S., Aboab, J., et al. (2005). Risk of post-traumatic stress symptoms in family members of intensive care unit patients.

American Journal of Respiratory and Critical Care Medicine, 171(9), 987–994. https://doi.org/10.1164/rccm.200409-1295OC
Bäckman, C. G., & Walther, S. M. (2001). Use of a personal diary written on the ICU during critical illness. *Intensive Care Medicine, 27*, 426–429. https://doi.org/10.1007/s001340000692
Barnes, D. (2018). *Constrained compassion: An ethnography exploring compassion in the hospital ward setting*. University of Nottingham. PhD thesis.
Bijttebier, P., Vanoost, S., Delva, D., Ferdinande, P., & Frans, E. (2001). Needs of relatives of critical care patients: Perceptions of relatives, physicians and nurses. *Intensive Care Medicine, 27*, 160–165. https://doi.org/10.1007/s001340000750
Blomberg, K., Griffiths, P., Wengström, Y., May, C., & Bridges, J. (2016). Interventions for compassionate nursing care: A systematic review. *International Journal of Nursing Studies, 62*, 137–155. https://doi.org/10.1016/j.ijnurstu.2016.07.009
Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa
Brummans, B. (2007). Death by document: Tracing the agency of a text. *Qualitative Inquiry, 13*(5), 711–727. https://doi.org/10.1177/1077800407301185
Bruni, A. (2005). Shadowing software and clinical records: On the ethnography of non-humans and heterogeneous contexts. *Organization, 12*(3), 357–378. https://doi.org/10.1177/1350508405051272
Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of Health & Illness, 4*(2), 167–182.
Calaresu, E. (2022). *La dialogicità nei testi scritti. Tracce e segnali dell'interazione tra autore e lettore* [The dialogicity in written texts. Traces and signals of interaction between the author and the reader] Pacini.
Caronia, L. (2019). Following and analyzing an artifact: Culture-through-things. In F. Cooren, & F. Malbois (Eds.), *Methodological and Ontological Principles of Observation and Analysis* (pp. 112–139). Routledge.
Caronia, L., & Mortari, L. (2015). The agency of things: How spaces and artefacts organize the moral order of an intensive care unit. *Social Semiotics, 25*(4), 401–422. https://doi.org/10.1080/10350330.2015.1059576.
Castro, E. M., Van Regenmortel, T., Vanhaecht, K., Sermeus, W., & Van Hecke, A. (2016). Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review. *Patient Education and Counseling, 99*(12), 1923–1939. https://doi.org/10.1016/j.pec.2016.07.026
Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. *Sage*.
Charon, R. (2007). What to do with stories: The sciences of narrative medicine. *Canadian Family Physician, 53*(8), 1265–1267.
Conway, J., Johnson, B., Edgman-Levitan, S., Schlucter, J., Ford, D., Sodomka, P., & Simmons, L. (2006). Partnering with patients and families to design a patient-and family-centered health care system: A roadmap for the future: A work in progress. *Institute for Family-Centered Care*.
Cooren, F. (2004). Textual agency: How texts do things in organizational settings. *Organization, 11*(3), 373–393. https://doi.org/10.1177/1350508404041998
Cooren, F. (2008). Between semiotics and pragmatics: Opening language studies to textual agency. *Journal of Pragmatics, 40*(1), 1–16. https://doi.org/10.1016/j.pragma.2006.11.018
Cooren, F. (2010). *Action and agency in dialogue: Passion, incarnation, and ventriloquism*. John Benjamins.
Cooren, F. (2012). Communication theory at the center: Ventriloquism and the communicative constitution of reality. *Journal of Communication, 62*(1), 1–20. https://doi.org/10.1111/j.1460-2466.2011.01622.x
Cooren, F., Fairhurst, G. T., & Huët, R. (2012). Why matter always matters in (organizational) communication. In P. M. Leonardi, B. A. Nardi, & J. Kallinikos (Eds.), *Materiality and organizing: Social interaction in a technological world* (pp. 296–314). Oxford University Press.
Crawford, P., Brown, B., Kvangarsnes, M., & Gilbert, P. (2014). The design of compassionate care. *Journal of Clinical Nursing, 23*(23–24), 3589–3599. https://doi.org/10.1111/jocn.12632
Crawford, P., Gilbert, P., Gilbert, J., Gale, C., & Harvey, K. (2013). The language of compassion in acute mental health care. *Qualitative Health Research, 23*(6), 719–727. https://doi.org/10.1177/1049732313482190
Davidson, J. E. (2009). Family-centered care: Meeting the needs of patients' families and helping families adapt to critical illness. *Critical Care Nursing, 29*(3), 28–34. https://doi.org/10.4037/ccn2009611
Davidson, J. E., Aslakson, R., Long, A., et al. (2017). Guidelines for family-centered care in the neonatal, pediatric, and adult ICU. *Critical Care Medicine, 45*(1), 103–128. https://doi.org/10.1097/CCM.0000000000002169
Davidson, J. E., Jones, C., & Bienvenu, O. J. (2012). Family response to critical illness: Post intensive care syndrome-family. *Critical Care Medicine, 40*(2), 618–624. https://doi.org/10.1097/CCM.0b013e318236ebf9
De Zulueta, P. (2013). Compassion in healthcare. *Clinical Ethics, 8*(4), 87–90. https://doi.org/10.1177/1477750913506484
De Zulueta, P. (2015). Suffering, compassion and 'doing good medical ethics'. *Journal of Medical Ethics, 41*(1), 87–90. https://doi.org/10.1136/medethics-2014-102355
Department of Health. (2013). *2010 to 2015 Government policy: Compassionate care in the NHS*. HMSO.
Dewar, B., Adamson, E., Smith, S., Surfleet, J., & King, L. (2013). Clarifying misconceptions about compassionate care. *Journal of Advanced Nursing, 70*(8), 1738–1747.
Di Gangi, S., Naretto, G., Cravero, N., & Livigni, S. (2013). A narrative-based study on communication by family members in intensive care unit. *Journal of Critical Care, 28*(4), 483–489. https://doi.org/10.1016/j.jcrc.2012.11.001
Dutton, J. E., Workman, K. M., & Hardin, A. E. (2014). Compassion at work. *Annual Review of Organizational Psychology and Organizational Behavior, 1*(1), 277–304. https://doi.org/10.1146/annurev-orgpsych-031413-091221
Eco, U. (1979). The role of the reader. In *Explorations in the semiotics of texts*. Bloomington: Indiana University Press.
Engman, A. (2019). Embodiment and the foundation of biographical disruption. *Social Science & Medicine, 225*, 120–127. https://doi.org/10.1016/j.socscimed.2019.02.019
Engström, A., & Söderberg, S. (2004). The experience of partners of critically ill persons in an intensive care unit. *Intensive and Critical Care Nursing, 20*(5), 299–308. https://doi.org/10.1016/j.iccn.2004.05.009
Epstein, R. M., & Street, R. L. (2007). *Patient-centered communication in cancer care: Promoting healing and reducing suffering*. Bethesda, MD: National Cancer Institute.
Frost, P. J. (1999). Why compassion counts. *Journal of Management Inquiry, 8*(2), 127–133. https://doi.org/10.1177/10564926998200
Frost, P. J., Dutton, J. E., Maitlis, S., Lilius, J. M., Kanov, J. M., & Worline, M. C. (2006). Seeing organizations differently: Three lenses on compassion. In S. R. Clegg, C. Hardy, T. B. Lawrence, & W. R. Nord (Eds.), *The Sage handbook of organization studies* (2nd ed., pp. 843–866). London: Sage.
Frost, P. J., Dutton, J. E., Worline, M. C., & Wilson, A. (2000). Narratives of compassion in organization. In S. Fineman (Ed.), *Emotion in organizations* (2nd ed., pp. 25–45). Sage.
Genette, G. (1997). *Paratexts: Thresholds of interpretation*. University of Cambridge Press.
Gibson, J. (1977). The theory of affordances. In R. Shaw, & J. Bransford (Eds.), *Perceiving, acting, and knowing: Toward an ecological psychology* (pp. 67–82). Erlbaum.
Gibson, J. (1979). *The ecological approach to visual perception*. Houghton Mifflin.
Gitelman, L. (2015). *Paper knowledge: Toward a media history of documents*. Duke University Press.
Goffman, E. (1981). *Forms of talk*. University of Pennsylvania Press.
Gooding, J. S., Cooper, L. G., Blaine, A. I., Franck, L. S., Howse, J. L., & Berns, S. D. (2011). Family support and family-centered care in the neonatal intensive care unit: Origins, advances, impact. *Seminars in Perinatology, 35*(1), 20–28. https://doi.org/10.1053/j.semperi.2010.10.004
Goodwin, C. (2007). Participation, stance and affect in the organization of activities. *Discourse & Society, 18*(1), 53–73. https://doi.org/10.1177/0957926507069457
Greenfield, S., Kaplan, S. H., Ware, J. E., Martin Yano, E., & Frank, H. J. L. (1988). Patients' participation in medical care. *Journal of General Internal Medicine, 3*, 448–457. https://doi.org/10.1007/BF02595921
Griffiths, R., & Jones, C. (2001). Filling the intensive care memory gap? *Intensive Care Medicine, 27*, 344–346. https://doi.org/10.1007/s001340000752
Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. Sage Publications.
Harré, R. (2002). Material objects in social worlds. *Theory, Culture & Society, 19*(5/6), 23–36. https://doi.org/10.1177/026327640201900502
Heritage, J. (1984). *Garfinkel and ethnomethodology*. Cambridge University Press.
Heritage, J. (2004). Conversation analysis and institutional talk: Analyzing data. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (pp. 223–245). Sage.
Heritage, J. (2012). Epistemics in action: Action formation and territories of knowledge. *Research on Language and Social Interaction, 45*(1), 1–29. https://doi.org/10.1080/08351813.2012.646684
Huggins, E. L., Bloom, S. L., Stollings, J. L., Camp, M., Sevin, C. M., & Jackson, J. C. (2016). A clinic model: Post–intensive care syndrome and post–intensive care syndrome–family. *Advanced Critical Care, 27*(2), 204–211. https://doi.org/10.4037/aacnacc2016611
Hull, M. S. (2003). The file: Agency, authority, and autography in an islamabad bureaucracy. *Language & Communication, 23*, 287–314. https://doi.org/10.1016/S0271-5309(03)00019-3
Hutchby, I. (2001). Technologies, texts and affordances. *Sociology, 35*(2), 441–456. https://doi.org/10.1177/S0038038501000219
Jackson, J. C., Girard, T. D., Gordon, S. M., Thompson, J. L., Shintani, A. K., Thomason, J. W., … Ely, E. W. (2010). Long-term cognitive and psychological outcomes in the awakening and breathing controlled trial. *American Journal of Respiratory and Critical Care Medicine, 182*(2), 183–191. https://doi.org/10.1164/rccm.200903-0442OC
Jacquemet, M. (1996). *Credibility in court*. Cambridge University Press.
Johansson, M., Hanson, E., Runeson, I., & Wåhlin, I. (2015). Family members' experiences of keeping a diary during a sick relative's stay in the intensive care unit: A hermeneutic interview study. *Intensive and Critical Care Nursing, 31*(4), 241–249. https://doi.org/10.1016/j.iccn.2014.11.002
Johansson, M., Wåhlin, I., Magnusson, L., Runeson, I., & Hanson, E. (2017). Family members' experiences with intensive care unit diaries when the patient does not survive. *Scandinavian Journal of Care Sciences, 32*(1), 233–240. https://doi.org/10.1111/scs.12454
Jones, C., Skirrow, P., Griffiths, R. D., Humphris, G., Ingleby, S., Eddleston, J., Waldmann, C., & Gager, M. (2004). Post-traumatic stress disorder-related symtoms in relatives of patients following intensive care. *Intensive Care Medicine, 30*, 456–460. https://doi.org/10.1007/s00134-003-2149-5
Kanov, J. M., Maitlis, S., Worline, M. C., Dutton, J. E., Frost, P. J., & Lilius, J. M. (2004). Compassion in organizational life. *American Behavioral Scientist, 47*(6), 808–827. https://doi.org/10.1177/0002764203260211
Kaplan, S. H., Greenfield, S., & Ware, J. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care, 27*(3), S110–S127.
Leonardi, P. M., Nardi, B. A., & Kallinikos, J. (Eds.). (2012). *Materiality and organizing: Social interaction in a technological world*. Oxford University Press.

Madden, L. T., Duchon, D., Madden, T. M., & Plowman, D. A. (2012). Emergent organizational capacity for compassion. *Academy of Management Review, 37*(4), 689–708. https://doi.org/10.5465/amr.2010.0424

Marsciani, F. (1999). La poltrona del dentista. La relazione medico-paziente nel "riunito" contemporaneo. In A. Semprini (Ed.), *Il senso delle cose.* Franco Angeli.

Mauksch, L. B., Dugdale, D. C., Dodson, S., & Epstein, R. (2008). Relationship, communication, and efficiency in the medical encounter: Creating a clinical model from a literature review. *Archive of Internal Medicine, 168*(13), 1387–1395. https://doi.org/10.1001/archinte.168.13.1387

Maynard, D. W. (2003). *Bad news, good news: Conversational order in everyday talk and clinical settings.* Chicago & London: University of Chicago Press.

McAdam, J. L., & Puntillo, K. (2009). Symptoms experienced by family members of patients in Intensive Care Unit. *American Journal of Critical Care, 18*(3), 200–209. https://doi.org/10.4037/ajcc2009252

McAllum, K., Fox, S., Ford, J. L., & Roeder, A. C. (2023). Communicating compassion in organizations: A conceptual review. *Frontiers in Communication, 8*, Article 1144045. https://doi.org/10.3389/fcomm.2023.1144045

Mead, N., & Bower, P. (2000). Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51*(7), 1087–1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Mickelson, R. S., Piras, S. E., Brown, L., Carlile, C., Drumright, K. S., & Boehm, L. (2021). The use and usefulness of ICU diaries to support family members of critically ill patients. *Journal of Critical Care, 61*, 168–176. https://doi.org/10.1016/j.jcrc.2020.10.003

Miller, K. I. (2007). Compassionate communication in the workplace: Exploring processes of noticing, connecting, and responding. *Journal of Applied Communication Research, 35*(3), 223–245. https://doi.org/10.1080/00909880701434208

Nicolini, D. (2007). Stretching out and expanding work practices in time and space: The case of telemedicine. *Human Relations, 60*(6), 889–920. https://doi.org/10.1177/0018726707080080

Norman, D. (1988). *The psychology of everyday things.* Basic Books.

Noy, C. (2015). *Thank you for dying for our country: Commemorative texts and performances in Jerusalem.* Oxford University Press.

Noy, C. (2020). Voices on display: Handwriting, paper, and authenticity, from museums to social network sites. *Convergence: The International Journal of Research into New Media Technologies, 26*(5), 1315–1332. https://doi.org/10.1177/1354856519880141

Nussbaum, M. (1996). Compassion: The basic social emotion. *Social Philosophy and Policy, 13*(1), 27–58. https://doi.org/10.1017/S0265052500001515

Orlikowski, W. J. (2007). Sociomaterial practices: Exploring technology at work. *Organization Studies, 28*(9), 1435–1448. https://doi.org/10.1177/0170840607081138

Park, J. S. Y., & Bucholtz, M. (2009). Introduction. Public transcripts: Entextualization and linguistic representation in institutional contexts. *Text & Talk, 29*(5), 485–502. https://doi.org/10.1515/TEXT.2009.026

Perez-Bret, E., Altisent, R., & Rocafort, J. (2016). Definition of compassion in healthcare: A systematic literature review. *International Journal of Palliative Nursing, 22*(12), 599–606. https://doi.org/10.12968/ijpn.2016.22.12.599

Pestian, T., Awtrey, E., Kanov, J., Winick, N., & Thienprayoon, R. (2023). The impact of organizational compassion in health care on clinicians: A scoping review. *Worldviews on Evidence-Based Nursing, 20*(4), 290–305. https://doi.org/10.1111/wvn.12664

Phillips, C. (2011). Use of patient diaries in critical care. *Nursing Standard, 26*(11), 35–43.

Pomerantz, A. (1980). Telling my side: "Limited access" as a fishing device. *Sociological Inquiry, 50*(3–4), 186–198.

Pomerantz, A. (1986). Extreme case formulation: A way of legitimizing claims. *Human Studies, 9*, 219–229. https://doi.org/10.1007/BF00148128

Reinhard, S. C., Given, B., Petlick, N. H., & Bemis, A. (2008). Supporting family caregivers in providing care. In R. G. Hughes (Ed.), *Patient safety and quality: An evidence-based handbook for nurses.* Agency for Healthcare Research and Quality (US).

Roulin, M. J., Hurst, S., & Spirig, R. (2007). Diaries written for ICU patients. *Qualitative Health Research, 17*(7), 893–901. https://doi.org/10.1177/1049732307303304

Shea, S., Wynyard, R., & Lionis, C. (Eds.). (2014). *Providing compassionate healthcare: Challenges in policy and practice.* Routledge.

Silverstein, M. (2019). Texts, entextualized and artifactualized: The shapes of discourse. *College English, 82*(1), 55–76. https://doi.org/10.58680/ce201930305

Simpson, A. V., Farr-Wharton, B., & Reddy, P. (2020). Cultivating organizational compassion in healthcare. *Journal of Management and Organization, 26*(3), 340–354. https://doi.org/10.1017/jmo.2019.54

Sinclair, S., Beamer, K., Hack, T. F., McClement, S., Raffin, B. S., Chochinov, H. M., & Hagen, N. A. (2017). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative Medicine, 31*(5), 437–447. https://doi.org/10.1177/02692163166634

Sinclair, S., McClement, S., Raffin-Bouchal, S., Hack, T. F., Hagen, N. A., McConnell, S., & Chochinov, H. M. (2016). Compassion in health care: An empirical model. *Journal of Pain and Symptom Management, 51*(2), 193–203. https://doi.org/10.1016/j.jpainsymman.2015.10.009

Sterponi, L., Zucchermaglio, C., Alby, F., & Fatigante, M. (2017). Endangered literacies? Affordances of paper-based literacy in medical practice and its persistence in the transition to digital technology. *Written Communication, 34*(4), 359–386. https://doi.org/10.1177/0741088317723304

Sterponi, L., Zucchermaglio, C., Fatigante, M., & Alby, F. (2019). Structuring times and activities in the oncology visit. *Social Science & Medicine, 228*, 211–222. https://doi.org/10.1016/j.socscimed.2019.03.036

Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: A review. *Canadian Medical Association Journal: Canadian Medical Association Journal, 152*(9), 1423.

Strauss, A., Fagerhaugh, S., & Suczet, B. (1985). *The social organisation of medical work.* University of Chicago Press.

Streeck, J., Goodwin, C., & LeBaron, C. (Eds.). (2011). *Embodied interaction: Language and body in the material world.* Cambridge University Press.

Tehranineshat, B., Rakhshan, M., Torabizadeh, C., & Fararouei, M. (2019). Compassionate care in healthcare systems: A systematic review. *Journal of the National Medical Association, 111*(5), 546–554. https://doi.org/10.1016/j.jnma.2019.04.002

Way, D., & Tracy, S. J. (2012). Conceptualizing compassion as recognizing, relating and (re)acting: A qualitative study of compassionate communication at hospice. *Communication Monograph, 79*(3), 292–315. https://doi.org/10.1080/03637751.2012.697630

Williams, J. (2017). Enhancing compassionate care: Recommendations for practice. *Nursing Standard, 31*(29), 55–60. https://doi.org/10.7748/ns.2017.e10181

Zinna, A. (2011). The object of writing. *Language Sciences, 33*(4), 634–646. https://doi.org/10.1016/j.langsci.2011.04.034