Roles and influence of people who accompany patients on visits to the doctor

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ABSTRACT

OBJECTIVES To determine the proportion of patients who are accompanied by another person (ie, partner, child, relative, friend) during visits to their doctors; to describe the demographic characteristics and role(s) assumed by the main accompanying person and the nature of the presenting dyads; and to describe the influence of the main accompanying person on the patient-doctor interaction.

DESIGN Prospective observational survey.

SETTING Family practices in London, Ont, and surrounding area.

PARTICIPANTS Eight family physicians completed surveys on 100 consecutive patients attending for both regularly scheduled and emergency visits.

MAIN OUTCOME MEASURES Roles and influence of the main accompanying person.

RESULTS Approximately one third (30.4%) of patients were accompanied during visits to their doctors. Children and patients older than 75 years most frequently had another person with them. Most patients (74.1%) were accompanied by one person who most often was female (72.6%) and between the ages of 21 and 40 years (53.6%). The accompanying person's role was most frequently described by doctors as an advocate for the patient (n=235, 68.5%). If the accompanying person was a child, however, the role was most often described as a silent observer (n=36, 68.6%). The influence of the main accompanying person on the patient-doctor encounter was usually described as positive (95.1%).

CONCLUSIONS Physicians report that people accompanying patients usually have a positive influence on medical encounters. Future studies need to include patients' and accompanying persons' perspectives.

RÉSUMÉ

OBJECTIFS Déterminer la proportion de patients qui sont accompagnés par une autre personne (par exemple le partenaire, un enfant, un parent ou un ami) durant leurs visites chez le médecin; décrire les caractéristiques démographiques et les rôles assumés par la principale personne accompagnatrice, ainsi que la nature des dyades qui se présentent; décrire l'influence de la principale personne accompagnatrice sur les rapports entre le médecin et le patient.

CONCEPTION Une étude d'observation prospective.

CONTEXTE Des cabinets de médecins de famille, à London (Ontario) et dans les environs.

PARTICIPANTS Huit médecins de famille ont répondu à une enquête portant sur 100 patients consécutifs qui venaient les consulter lors d'un rendez-vous ou pour une visite d'urgence.

PRINCIPALES MESURES DES RÉSULTATS Les rôles et l'influence de la principale personne qui accompagnait le patient.

RÉSULTATS Environ le tiers (30,4%) des patients étaient accompagnés durant leur visite chez le médecin. Les enfants et les personnes de plus de 75 ans comptaient au nombre de ceux le plus fréquemment accompagnés par une autre personne. La majorité des patients (74,1%) étaient accompagnés par une seule personne, qui le plus souvent était de sexe féminin (72,6%) et dont l'âge variait entre 21 et 40 ans (53,6%). Le rôle de la principale personne accompagnatrice a le plus souvent été décrit comme celui de porte-parole du patient (n=235, 68,5%). Dans les cas où la personne accompagnatrice était un enfant, son rôle était le plus souvent décrit comme étant un observateur silencieux (n=36, 68,6%). L'influence de la principale personne qui accompagnait le patient sur les rapports entre le médecin et le patient était généralement décrite comme étant positive (95,1%).

CONCLUSIONS Les médecins rapportent que la personne qui accompagne le patient a habituellement une influence favorable sur la visite médicale. Les études futures devraient inclure aussi le point de vue du patient et celui de la personne accompagnatrice.

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How does the presence of an accompanying person influence a patient-doctor interaction in family practice? Information on interviewing couples or families with problems is readily available in the social science[1,2] and family medicine[3] literature. While earlier research has documented the importance of patient-doctor communication on patient satisfaction,[4-6] symptom resolution,[7] reduction of concern,[8] and physiologic outcomes,[9-11] very little research has examined the influence of people who accompany patients on everyday visits to the doctor. The few studies that have been conducted focus on the elderly[12,13] or children[14,15] and cancer patients.[16]

The elderly population has been studied primarily in the context of internal medicine consultations.[12,13] Children's visits often provide the "ticket of entry" for parents to attend to their own medical needs.[15] Pantell et al[14] found that physicians' interactions with parents and with children were different and concluded that children were not active participants in their own medical care. Accompanying people have been found to assume various roles that can facilitate or impede encounters and support or detract from patient-doctor relationships.[12,13,17]

No one study has examined the prevalence of visits to family physicians' offices during which patients of all ages are accompanied by other people. Few studies have focused specifically on family practice settings and none, to our knowledge, have considered the Canadian context.[15,18] Before embarking on a large intervention study examining interactions among physicians, patients, and accompanying people, we thought it important to establish the prevalence and the characteristics of the various dyads presenting in family practice. Therefore, this study aimed to determine the prevalence of office visits during which patients were accompanied by other people (eg, partner, child, relative, friend); the demographic characteristics and role(s) assumed by the main accompanying person and, from that, the nature of presenting dyads; and the influence of the main accompanying person on patient-doctor interactions. This study was approved by the Review Board for Health Sciences Research Involving Human Subjects at The University of Western Ontario.

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METHODS

Sample

A convenience sample of eight family physicians was recruited by the investigators. The physicians, equally drawn from urban and rural settings in and around London, Ont, represented both academic (three) and community-based (five) practices. The two female and six male physicians were all certificants of the College of Family Physicians of Canada. Initial recruitment conducted by telephone was followed by a letter of information and a consent form mailed to physicians' offices.

Procedures

Upon return of the consent form, a package with 100 survey questionnaires and an instruction sheet was mailed to each physician. Physicians were asked to complete the 12-question survey for each of 100 consecutive patients attending their offices for both regularly scheduled and emergency visits.

The survey sought information on patients' demographic characteristics (age and sex); presenting problem (acute or chronic); whether or not a patient was accompanied by another person; how many people accompanied a patient; demographics of the main accompanying person (relationship to the patient, age, and sex); whether the accompanying person(s) had a booked appointment; physician's perception of the most relevant role assumed by the main accompanying person (silent observer, patient advocate, interpreter, spokesperson, unbooked patient); how the physician would characterize the interaction of the main accompanying person with both the patient and the doctor (supportive, obstructive, caring, respectful, angry, other); the physician's perception of the overall influence of the main accompanying person on the patient-doctor interaction (positive, negative, neutral); and the length of time the physician had known the patient.

Survey content, wording, and format were reviewed by the physician partners of the Thames Valley Family Practice Research Unit's Liaison Committee and were pilot tested also in

two physicians' offices. These physicians' recommendations were incorporated into the survey, and the role descriptions and influence of accompanying people were deemed clear.

Analysis

A sample size for number of patient visits was calculated using a sample size table for descriptive studies involving a dichotomous variable.[19] Given the findings of Knishkowy and colleagues,[18] we expected that the proportion of patient visits involving an accompanying person would be approximately 35%. Taking a 95% confidence interval, a type II error rate of .10, and an expected proportion of between .30 and .40 patient visits involving accompanying persons, we needed a minimum of 346 documented patient visits to estimate the prevalence of accompanied patient visits.

The survey listed five categories of relationships for the presenting dyads. In the absence of data with which to estimate prevalence, we assumed a 20% prevalence for each category. To detect this within a confidence interval of .10, we required 246 dyads. Estimating the prevalence to be 35%, we then needed more than 400 encounters. Modest oversampling and rounding led us to seek eight physicians for 100 encounters each.

All analyses were performed using the Statistical Package for the Social Sciences (SPSS-PC). Preliminary data analysis involved simple descriptive summary statistics. Data were grouped into naturally occurring patient and accompanying person configurations, or dyads. χ^2 analyses were conducted to explore associations between dyads and patients' ages, relationships with accompanying people, and other visit variables.

RESULTS

Descriptive analyses

The eight participating physicians completed 800 questionnaires over 2 weeks in July 1995. In the total sample (N=800), 60.4% of patients were female, and 19.4% were younger than 20 years, 38% between 21 and 40, 18.3% between 41 and 60, and 24.3% older than 61. Patients had acute (56.7%) and chronic (43.3%) problems.

Approximately one third (30.4%) of patients were accompanied during their visits. Children and patients older than 75 were most frequently accompanied (**Table 1**); the proportions in these two groups were significantly larger than for all other age groups ($\chi^2=274.53$, $df=5$, $P<.001$). Accompanied patients were similarly distributed by sex, but were more likely to have acute problems than unaccompanied patients (**Table 2**). Children's presenting problems were rarely chronic (23.2%); seniors' concerns were primarily chronic (64.4%).

Most patients (74.1%) were accompanied by one person, who most often was female (72.6%) and between the ages of 21 and 40 years (53.6%). The accompanying person was usually a parent (46.0%) or spouse (24.3%). Rarely did the accompanying person have a booked appointment (n=25, 9.8%). Accompanying people's roles were most frequently described by physicians as advocates for patients (n=235, 68.5%). If the accompanying person was a child, however, the role was most often identified as a

Table 1. Proportion of accompanied patients in various age groups

AGE GROUP (Y)	TOTAL SAMPLE	NO. (%) OF PATIENTS ACCOMPANIED
0-12	104	102 (98.1)
13-20	58	19 (32.8)
21-40	267	57 (21.3)
41-60	163	19 (11.7)
61-74	115	18 (15.7)
75 and older	76	23 (30.3)
TOTAL	783*	238 (30.4)

**Data on age or whether there was an accompanying person were missing for 17 patients.*

Table 2. Sex and presenting problems of accompanied and unaccompanied patients

CHARACTERISTIC	ACCOMPANIED PATIENT	UNACCOMPANIED PATIENT	TOTAL, *P*
Sex	(n = 236)	(n = 538)	(n = 774)* NS
• Female	63.6	58.9	60.3
• Male	36.4	41.1	39.7
Presenting problem	(n = 233)	(n = 536)	(n = 769),† <.001‡
• Acute	66.5	52.4	56.7
• Chronic	33.5	47.6	43.3

NS—*not significant*
**Data were missing for 26 subjects.*
†Data were missing for 31 subjects.
‡$\chi^2 = 12.57$, $df = 1$, $P<.001$.

silent observer (n=36, 68.6%). Physicians documented accompanying people's behaviour during interactions as primarily supportive to both the patient (82.8%) and the doctor (69.8%). The influence of the main accompanying person on the patient-doctor encounter was most often described by physicians as positive (95.1%).

Exploratory analyses: dyad configurations

Six types of patient–accompanying person dyads were identified (**Table 3**): child accompanied by a parent, patient accompanied by spouse, parent accompanied by child(ren), patient (child or adult) accompanied by sibling, senior accompanied by adult child, and adult child accompanied by parent.

The most common dyad was child accompanied by parent (45.8%); children of both sexes younger than 20 years were frequently accompanied by a parent, most often the mother (94.4%). The second most common dyad was adult patient accompanied by partner (24.4%). Two age groups predominated: 21 to 40 years (36.2%) and older than 61 years (37.9%). Women (59.6%) were more likely to be accompanied by their spouses. The third common dyad was patient accompanied by child younger than 20 years. Women (91.4%) between the ages of 21 and 40 (91.5%) were more often accompanied by children younger than 20. While most of these patients (76.5%) were accompanied by one child, 11.8% were accompanied by three or more children. The fourth common dyad involved patients accompanied by siblings. In this group (a small group, 10.5% of all patient encounters involving accompanying people), 40% were elderly patients most often accompanied by a sister.

Results of χ^2 analyses revealed a pattern of relationships between the four most common dyad configurations and the nature of presenting problems, role of accompanying people, and influence of accompanying people's presence on visits. Both the child accompanied by parent dyad and the parent accompanied by child dyad were associated primarily with acute presenting problems (78.8% and 82.9%, respectively). Patients in the remaining two dyads (adult accompanied by spouse and patient accompanied by sibling) were almost evenly split between acute and chronic presenting problems (**Table 4**).

In the child accompanied by parent and patient accompanied by sibling dyads, the role of the accompanying person was identified as primarily that of an advocate (89.0% and 88.0%, respectively); spouses attending their partners' visits did so primarily as advocates (58.9%) and observers (33.9%). In the parent accompanied by child dyad, the role of the child was most often identified as that of observer (68.6%) or unbooked patient (25.7%) (**Table 5**).

The influence of accompanying people on patient encounters was identified as largely positive for all dyad configurations except for the parent accompanied by child dyad. In only 27.8% of these encounters was the influence of the accompanying child found to be positive; more often children were found to have a neutral (58.3%) and sometimes even negative influence (13.9%) on the visit (**Table 6**).

DISCUSSION

This study found a 30.4% prevalence of patients accompanied by other people, which agrees with prior research.[19] Results also confirmed specific groups (dyads) noted in prior studies[12-15] (ie, child

Table 3. Numbers and proportions of the six dyads

DYADS	N (%)
Child accompanied by parent	109 (45.8)
Adult accompanied by spouse	58 (24.4)
Parent accompanied by child	36 (15.1)
Child or adult accompanied by sibling	25 (10.5)
Senior accompanied by adult child	9 (3.8)
Adult child accompanied by parent	1 (0.4)
TOTAL	238 (100.0)

Table 4. Proportion of acute and chronic problems in the four most common dyads

DYAD	ACUTE N (%)	CHRONIC N (%)
Child accompanied by parent*	82 (78.8)	22 (21.2)
Adult accompanied by spouse	28 (48.3)	30 (51.7)
Parent accompanied by child*	29 (82.9)	6 (17.1)
Child or adult accompanied by sibling	12 (48.0)	13 (52.0)

$\chi^2 = 24.1$, $df = 3$, $P < .001$.

**Data for presenting problem were missing for five child accompanied by parent dyads and for one parent accompanied by child dyad.*

Table 5. Role of the accompanying person in the four most common dyads

DYAD	OBSERVER N (%)	ADVOCATE N (%)	UNBOOKED PATIENT N (%)
Child accompanied by parent	4 (3.7)	97 (89.0)	8 (7.3)
Adult accompanied by spouse*	19 (33.9)	33 (58.9)	4 (7.1)
Parent accompanied by child*	24 (68.6)	2 (5.7)	9 (25.7)
Child or adult accompanied by sibling	2 (8.0)	22 (88.0)	1 (4.0)

$\chi^2 = 97.6$, $df = 6$, $P < .001$.
**Data for role of accompanying person were missing for two adult accompanied by spouse dyads and one parent accompanied by child dyad*

Table 6. Influence of the main accompanying person on the consultation for the four most common dyads

DYAD	POSITIVE N (%)	NEUTRAL N (%)	NEGATIVE N (%)
Child accompanied by parent*	102 (95.3)	4 (3.7)	1 (0.9)
Adult accompanied by spouse*	46 (82.1)	8 (14.3)	2 (3.6)
Parent accompanied by child	10 (27.8)	21 (58.3)	5 (13.9)
Child or adult accompanied by sibling	22 (88.0)	1 (4.0)	2 (8.0)

$\chi^2 = 82.0$, $df = 6$, $P < .001$.
**Data for influence on consultation were missing for two child accompanied by parent dyads and two adult accompanied by spouse dyads.*

accompanied by parent, parent accompanied by child) and identified new dyads for future research, particularly adults accompanied by siblings.

The positive influence of accompanying people on patient-doctor interactions supports the value of family members participating in family medicine visits[20,21] and the importance of involving families in the care of patients.[20,21] McDaniel et al[3] emphasize the importance of developing positive working alliances with both patients and family members. When a new patient joins the practice, they recommend meeting with family members early on, particularly if the patient has a chronic illness.[3]

Given that physicians reported that accompanying people had a positive influence, we conclude that problems of triangulation were not apparent. The concept of triangulation, which emanates from the family therapy literature, occurs when a third person is drawn into a two-person system to deflect or diffuse conflict or anxiety.[3] The nature of the everyday encounters described in this study might have made them exempt from such emotional responses, or the data collection method might not have been sensitive to such a complex process.

This study found a high prevalence of accompanying people with children and with the elderly. Similar to the findings of Pantell et al,[14] the role of parents accompanying children was that of advocate. In contrast to findings in earlier work,[15] this study found that only rarely were parents "unbooked patients" or using the child as their "ticket of entry" into the doctor's office for medical care.

The finding that one third of patients older than 75 were accompanied on their visits to doctors has important clinical implications. While prior research[12,13] has documented the negative influence of accompanying people during encounters with elderly patients, our findings revealed that accompanying people were often advocates and that overall interactions were reported as positive. This might reflect physicians' relationships with both patients and family members, taking into account the needs and concerns of both parties. It might also be that accompanying people provide important information about patients' problems and management, which facilitates doctors' care.

Unique to this study was the identification of three other dyads: patients accompanied by spouses, parents accompanied by children, and elderly patients accompanied by elderly siblings. Patient-spouse dyads fell primarily into two groups: women patients between the ages of 21 and 40 accompanied by their partners and seniors accompanied by spouses. Younger women, we speculate, are being accompanied by their partners during prenatal and postnatal visits, and this could reflect the increasing involvement of men in their partners' pregnancies and postnatal care. As for the elderly couples, with the

Key points

- Approximately one third of patients attending family practices in London, Ont, were accompanied by another person, who was usually female and most often acted as an advocate for the patient.
- The most common dyads were child accompanied by parent, adult accompanied by spouse, and parent accompanied by child.
- The influence of the accompanying person was almost always described as positive by participating physicians.

ever-increasing number of seniors in our population, many will be accompanied by their partners due to cognitive or physical limitations.

The most troublesome dyad was parent accompanied by child(ren). As the number of children present during an office visit increased, the encounter was more often described as neutral or at worst negative. This problem has not been identified before in the literature and suggests a need for better child care options in doctors' offices. Women with complex problems might be reluctant to raise concerns if disruptive children are present (eg, disclosure about violence).

A dyad not dominant in our study was elderly patient accompanied by adult child. This is contrary to findings in the literature that highlight the important caregiving role played by adult children in their parents' health care.[3,12,13,22] Also notable was the number of elderly female patients accompanied by elderly female siblings. These two dyads require further exploration to gather additional data to support the positive interaction reported for the elderly sibling dyad and to investigate the reported absence of the adult–child caregiver role.

Limitations

While this study included only eight practices, the physician sample included both urban and rural, academic and community-based, recently graduated and experienced, male and female physicians. Another limitation was the sole use of physicians' assessment of the role and influence of accompanying people on patient-doctor interactions. Future studies could include other sources of data (ie, patients' perceptions) and use qualitative methods. Also, patients' ethnicity was not documented, limiting generalizability of the findings to culturally diverse patients in need of interpreters.

Conclusion

This study documented a substantial prevalence of patients accompanied by other people and explored doctors' perspectives on the influence of accompanying people on patient-doctor encounters. Future studies need to include patients' and accompanying peoples' perspectives. Qualitative methods might be the most effective way to examine these important viewpoints. Qualitative methods might also provide opportunities for further exploring dynamic interchanges in the dyads and in the subsequent triad that evolves in doctor–patient–accompanying person interactions.

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