

# Physician Perspectives on the Elderly Patient–Family Caregiver–Physician Encounter

Mark J. Yaffe MD CM M MCISc CCFP FCFP<sup>1,2</sup> and Jacqueline Klvana MD CM CCFP<sup>1</sup>

<sup>1</sup>Department of Family Medicine, St. Mary's Hospital, Montreal, Canada

<sup>2</sup>McGill University Faculty of Medicine, Montreal, Canada

**Key words:** eldercare, informal caregivers, family physicians, office encounters, doctor attitudes, doctor-patient relationship

## Abstract

**Background:** Eldercare often necessitates the presence of a family caregiver at the senior's visit to a doctor's office. Studies indicate that some caregivers are not satisfied with these encounters or with their outcomes. An understanding of the dynamics of these complex interactions is required.

**Objectives:** To explore family physicians' attitudes to interfacing with family caregivers of the elderly, to identify factors within the family doctor-elderly patient-caregiver encounters in the office setting that might be problematic for physicians, to ascertain factors that might contribute to doctors' behaviors and concerns, and to propose possible solutions for optimizing the outcomes of these visits.

**Method:** A questionnaire for self-administration was mailed to 200 family physicians in Montreal, Canada who are affiliated with two community secondary care and one tertiary care hospital and involved in geriatric office practice. The survey focused on family physician attitudes, concerns and observations on the interactions among themselves, elderly patients and their family caregivers during office visits.

**Results:** A total of 142 completed questionnaires were returned with a 71% response rate. Most family doctors felt that it was their responsibility to respond to caregiver concerns (90.6%) and that they were generally meeting their needs (94.2%). In contrast, 81% found this activity stressful and that as few as three such encounters per day were sufficient to generate stress. Causes of stress included: a) concern regarding misdiagnosis, b) different agendas or conflicting responses of patient and caregiver to doctors' suggestions, and c) reluctance of the elderly or the caregiver to use community resources. A common physician strategy was reliance on acquired professional experience to solving problems of the elderly or of their caregivers.

**Conclusions:** Despite the stress involved, physicians are interested in assisting caregivers in the management of the elderly. Many doctors lack adequate knowledge about or confidence in community resources. Clinicians may require enhanced skills in conflict resolution necessary to achieve optimal outcomes.

*IMAJ 2002;4:785–789*

For Editorial see page 812

Family members provide at least 80% of the care necessary to keep their frail relatives in the community [1,2]. This often includes the family caregiver accompanying the elderly person to a doctor's office. Thus, the doctor-patient encounter, which is commonly dyadic (an interaction between two people) becomes triadic (an interface between three). The role of the caregiver during these visits may not always be predictable [3,4]: it may be facilitative

(encouraging or empowering the patient), supportive (promoting or extending the patient viewpoint), or neutral (the caregiver being present but disengaged from the visit). It can also be antagonistic, such as the co-opting of an agenda to meet the caregiver's own needs.

The triadic interaction may challenge physician skills in eldercare [5,6] and has the potential to generate ethical dilemmas [7]. Furthermore, in the care of their elderly patients, doctors may find themselves not only assisting caregivers in problem-solving and referral to community resources but also assessing the caregiver's health and coping skills [8]. The latter activity takes on added significance in view of the recent finding that family caregiving is an independent risk factor for mortality among elderly spousal caregivers [9].

What is known about the interaction between family physician, elderly patient, and family caregiver? A Canadian survey of urban family caregivers of frail elderly reported that 39% of caregivers expressed some degree of unhappiness about their own contacts with family physicians caring for their family elders [10]. The reasons for discontent included: some doctors were non-supportive, lacked compassion, provided insufficient information to patient or caregiver, were responsible for possible disease misdiagnosis, inappropriately or over-prescribed medications, and prematurely terminated community services. Similar findings come from a recent survey of the American Alzheimer's Association, in which 68%, 72%, and 76% of caregivers reported not receiving adequate information from doctors on medications, on patients' abilities to do daily tasks, and on support groups, respectively [11]. A Cochrane Review has documented similar problems among caregivers of stroke victims [12].

How do doctors perceive the involvement of family members at office visits? Brown et al. [13] found that family physicians regarded family accompaniment of patients (of all ages) to the doctor's office as generally positive, contradicting other reports that accompaniment had a negative influence on doctors' care of the elderly. They observed that further research into the specific encounter of physician with the elderly and their family caregivers was desirable. This may be achieved through structured coding of audio-taped records of office visits [4], but this approach does not necessarily permit the identification or understanding of attitudes that may underlie comments or decisions made during the encounter. The present study was therefore designed to explore the elderly patient-physician-caregiver triad further, specifically from the physician's perspective. We hypothesize that while doctors are well-intentioned

toward elderly patients and their caregivers, certain factors in the triadic office encounter may be problematic for physicians. Identification of such issues might generate solutions to improve outcomes for the elderly patient, the family caregiver, and the physician.

## Subjects and Methods

### Selection of subjects

This Canadian survey used a sample of family doctors affiliated with three Montreal hospitals – two community secondary care and one tertiary care facility. These institutions serve a catchment area in which 23% of the population are elderly, some of whose caregivers had previously identified difficulties with their relatives' doctors [10]. The family medicine departmental chiefs were asked to provide the names of their staff doctors who met study inclusion criteria of regular office practice including elderly patients, as well as an up-to-date mailing address. From a total of 226 doctors, 13 were excluded because they did not care for elderly in ambulatory settings, 4 because they were honorary members and not in active practice, 8 as a result of erroneous or incomplete mailing addresses, and one name that appeared on two departmental lists was considered only once. This process generated a sample of 200 family doctors.

### Questionnaire

One of the authors (M.J.Y.) conducts frequent workshops for family physicians on caregiver issues as part of a McGill University Faculty of Medicine Continuing Education Program. Comments and concerns of participating physicians from across Canada and the United States regarding their interface with caregivers were cumulatively recorded. These formed the basis for this survey, and an English-language questionnaire designed for mailing and self-administration by physicians, using a framework derived from Dillman, was developed and piloted [14].

The questionnaire contained 23 questions. Eleven multiple choice-type with a single response option addressed physicians' personal and practice demographics as well as participation in continuing medical education programs on caregiver issues. Two five-point Likert-style inquiries explored doctors' feelings about their encounters with caregivers. The remaining 10 items addressed process of care issues in the doctor-elderly patient-family caregiver triad, using questions of either multiple response option or rank order preference.

Approval of the center's research ethics committee was obtained and confidentiality was assured by means of the identification numbers of anonymous respondents. An explanatory cover letter, the questionnaire, a return postage-paid pre-addressed envelope for the completed survey, and a separate stamped pre-addressed postcard bearing the responder's name were sent to the participating family doctors. Four weeks later an identical package was sent to the non-responders. Requests for study participation were made at regularly scheduled meetings in two of the three departments. Statistical analysis of responses included frequency tables, chi-square analysis and Fisher's exact test, using an SPSS package. A probability level of 0.05 was considered to represent statistical significance.

## Results

### Characteristics of respondents

The response rate was 71% (142/200). Among the respondents 82.1% were between the ages of 30 and 49. The practice types were representative: 34.5% were in group practices, 30.3% in teaching family medicine centers, 23.9% in private practice, and 11.9% in government-run community clinics. Physician remuneration was primarily (80.4%) fee-for-service. Forty-three percent of doctors saw 10 to 19 patients per day, 34% saw 20–29, and the remaining 23% were equally divided – seeing either more or less than these figures. With regard to encounters with caregivers, 78.3% of doctors saw 1–3 caregivers per day, and just over 40% of physicians were themselves caregivers to an aging relative or friend.

A research assistant blinded to the study identified the names of non-responders by removing from the mailing list those who returned postcards on completion of the questionnaires. This enabled some comparison of responders and non-responders. Males comprised 60.3% of responders and 70.6% of non-responders. Responders' years in practice was derived from the survey, while estimates for non-responders assumed that most doctors would commence practice within a year of being licensed (information obtainable from the directory of the College of Physicians of the Province of Quebec). For responders and non-responders, respectively, the distribution was: for 1–5 years in practice: 9.9 vs. 10.2% for 1–5 years; 25.5 vs. 23.5% for 6–10 years, 24.8 vs. 13.2% for 11–15 years, 22.7 vs. 23.5% for 16–20 years, and 17 vs. 29% for more than 20 years.

### Physicians' roles

A total of 90.6% of doctors felt moderately strongly to strongly that non-medical concerns of caregivers should be within the realm of their responsibility. A comparably large majority (94.2%) felt they were meeting caregivers' needs and that caregivers would perceive their needs as being met occasionally to most of the time (as opposed to never, rarely, or always). The physicians who held these beliefs had been in practice for 6–20 years ( $P = 0.005$ ), were between the ages of 30 and 49 ( $P = 0.02$ ), and were remunerated fee-for-service ( $P = 0.009$ ).

### Physicians as caregivers

Of the 142 respondents 57 (40.1%) were themselves caregivers of an elderly relative or friend. Of these, 82.5% felt this made them more sensitive to the general needs of caregivers than if they had not been caregivers; 52.6% stated that being a caregiver made them more responsive to others in that role; and 3.5% claimed that being a caregiver themselves made them reluctant to deal with caregiver issues. However, no statistical differences were found in responses to issues in this study between doctors who were caregivers and those who were not.

### Practice patterns

Physicians were asked to identify their most common response to caregiver problems or crises. Sixty-four percent of doctors counseled the caregiver themselves, 25% referred them directly to social services, and the remaining 11%

directed caregivers to nurses, other physicians, or psychologists/psychiatrists.

### Stressful practice

Almost 81% of respondents reported stress in the management of caregiver issues occasionally to most of the time (as opposed to never, rarely, or all the time), and 75.5% felt moderately strongly to strongly that the payment system did not adequately remunerate for the stress involved in interacting with caregivers. To deal with the practice stress the doctors reported a number of strategies [Table 1]. Although acquisition of new knowledge or skills through continuing medical education programs is a form of stress management, 74.6% had not attended any learning activity related to caregiver issues during the 3 years prior to this study. The reasons for non-attendance are summarized in Table 2. However, physicians did employ a range of other information resources to help them with caregivers [Table 3]. Interestingly, almost two-thirds relied on "acquired professional experience." The doctors who used this strategy were less likely to have attended a continuing medical education event with some caregiver content than those who relied on other approaches ( $P = 0.05$ )

### Process of care

Table 4 presents 18 issues concerning practice physicians. For those most often cited, multivariate analyses compared those doctors who selected a particular issue versus those who did not. Physicians who worried about difficulty in reaching a diagnosis during the triadic encounter tended to regard these encounters as stressful, occasionally to most of the time ( $P = 0.06$ ). These particular physicians were in practice for 6–20 years ( $P = 0.04$ ) and had 10–29 patient encounters a day ( $P = 0.05$ ), which included 1–3 caregivers ( $P = 0.04$ ). They worried about the potential for differing agendas between patient and caregiver ( $P = 0.05$ ), and felt they lacked knowledge about community resources ( $P = 0.04$ ). In contrast, doctors who were troubled about the correctness of their diagnosis felt knowledgeable about community resources, but not confident that such resources would meet patients' needs ( $P = 0.05$ ) or be delivered in time ( $P = 0.03$ ). Those clinicians who believed that the patient or caregiver might be reluctant to use available community

**Table 4.** Factors impacting on the triad encounter\* (n = 142)

Problem diagnosis may be difficult	79.6%
Caregiver and patient have different agendas	63.4%
Elderly reluctant to use suggested community resources	62.0%
The problem may be misdiagnosed	57.0%
Medications may be inappropriate	57.0%
Caregiver and elderly have different/conflicting responses to doctors' suggestions	50.7%
Caregiver reluctant to use suggested community resources	42.3%
Caregiver intrudes into care of elderly patient	31.0%
Doctor feels he/she is not seen as always compassionate/supportive	22.5%
Doctor feels caregivers blame him/her for lack/termination of community services	16.9%
Doctor needs to put his/her agenda before that of elderly patient/caregiver	16.2%
Doctor takes no active part in discussing placement issues	10.6%
Doctor has difficulty with patients of other cultural/linguistic backgrounds	7.7%
Doctor perceives inadequacy of community services	1.4%
Doctor lacks time for patient care	1.4%
Doctor feels there are no ideal solutions for elderly patients	1.4%
Hospital care is not always available for the elderly	0.7%
Home visits are ideal for care of the elderly	0.7%

\* More than one response possible / doctor

services admitted to a lack of knowledge about those services ( $P = 0.005$ ). These physicians also had 6–20 years of practice experience ( $P = 0.01$ ) and saw 10–29 patients a day ( $P = 0.04$ ). They relied most often on acquired professional experience to guide them ( $P = 0.05$ ) and believed that there was a lag time between referral to and provision of community services ( $P = 0.03$ ).

Finally, doctors who were concerned that the elderly patient and family caregiver might have different or conflicting responses to their suggestions acknowledged their own difficulty communicating with caregivers ( $P = 0.02$ ). They relied on acquired professional experience to guide them ( $P = 0.05$ ) and were also concerned about delays between referral and provision of community services ( $P = 0.02$ ).

**Table 1.** Support for physicians\* (n = 142)

Colleagues	68.3%
Family members	52.8%
Friends	38.0%
Office personnel	31.0%
Do not seek support	14.1%
Not applicable	5.6%
Seek support, but do not get it	2.8%
Professional support group	2.1%
Recreational activities	2.1%
Patients	0.7%

\* More than one response possible / doctor

**Table 2.** Reasons for non-attendance at continuing education programs on caregiving\* (n = 142)

Demands for programs on other topics	38.7%
Unaware of caregiver programs	30.3%
No time to attend	25.4%
No interest in attending	11.3%
Have sufficient knowledge	7.0%
Courses not available	5.6%
Courses too expensive	2.8%
Courses not relevant to practice	1.4%
Courses not helpful	1.4%

\* More than one response possible per doctor

**Table 3.** Sources of information on community services\* (n = 142)

Social service departments	64.1%
Acquired professional knowledge	63.4%
Physician colleagues	44.4%
Nurses	28.2%
Reference lists	16.9%
Physiotherapy services	9.9%
Occupational therapy services	8.5%
Government-run community clinic	4.2%
Hospital medical service	1.4%
Patients	1.4%
Personal caregiver experience	1.4%

\* More than one response possible / doctor

## Discussion

While sick people may prefer more direct family involvement in their healthcare [15], for the caregiver this might have adverse implications for their own emotional, physical, financial, familial, or vocational states [16]. Optimally, caregivers should be able to turn to a vast array of health professionals for help. In reality, however, there are generally insufficient nurse practitioners available, many psychologists may be inaccessible because of their professional fees, and social workers' heavy involvement in assisting with instrumental tasks limits their counseling roles. Given the broad perspectives that family doctors have of family function and family response to illness [17], they are well placed in most healthcare systems to assist both the frail elderly and their family caregivers [16]. For the caregivers of Alzheimer patients, primary care doctors have in fact been shown to be the main source of information [11]. However, physicians taking on this role will likely need to explore the depth of their knowledge about caregiver issues as well as their overall confidence in this activity [18].

This research was conducted in a catchment area that included a multicultural population consisting of 23% elderly. This proportion of seniors is higher than in many other communities and therefore the views of the doctors might be a reflection of evolving physician attitudes in regions with growing numbers of elderly. The study's high response rate may suggest that the topic was of sufficient concern and relevance to motivate doctors to participate. The involvement from different practice settings and the comparability of the available data on respondents and non-respondents suggest the generalizability and representativeness of the findings.

According to the number of years in practice the respondents were predominantly an experienced group, at a time in their medical career when energy and enthusiasm for the challenge of patient care should be high. The physicians endorsed being aware of caregiver issues, which is consistent with findings elsewhere that family doctors are comfortable asking adult patients about personal, non-medical or non-physiologic issues [19]. Nevertheless, some primary care doctors do not meet caregiver's expectations or needs [10,11]. This may be explained by our findings that: a) doctors relied strongly on acquired professional experience for knowledge of community services, and b) they turn to colleagues for help in dealing with stressful practice issues. While this may be a natural course, it is not necessarily the most useful or productive [20]. Furthermore, continuing medical education programs have traditionally been promoted as a means to improve clinical proficiency. The study cohort's low attendance at learning events that directly or indirectly addressed caregiver issues raises the question whether the doctors have adequate knowledge and skills to make them feel comfortable with their elderly patients and family caregivers.

The finding that doctors viewed attending to as few as three caregivers per day troublesome validates their perceptions that interaction with such individuals is stressful. Paradoxically, while seeing reasonably large numbers of patients per day, only 1.4% of doctors identified lack of time as a problem in the triadic relationship. Another problem was remuneration, since most respondents worked in a fee-for-service system that paid more for

physical examination or diagnostic and therapeutic procedures than for listening or talking.

The differing needs of care-receivers and caregivers disturbed the doctors. Indeed, complex ethical issues can arise when a family member becomes involved in medical decision-making [21]. Moreover, the burden of caregiving may be so onerous as to warrant an equal or higher priority than the medical situation itself, which may lead to conflicts with the physician.

In reality, the training of most physicians does not address in any depth the skills required to handle conflict resolution. This suggests a broad agenda for continuing medical education programs, which, according to physicians' comments in this study, should be well advertised, have clearly stated teaching goals, and take place at convenient times. The content of such courses should include physician approaches to triadic office encounters, case management strategies for caregivers in crisis, active listening-skill options, strategies to handle conflict and achieve win-win solutions between family members, and the role that depression and resistance may play in communication with either caregiver or care-receiver. In addition, since doctors claim that they do address issues with caregivers, they may need to acquire new skills to transmit information to caregivers who are under such stress that they may forget or not process the information given to them [11].

Physicians were concerned that community services were either inadequate or not rapid enough to meet elderly patient or caregiver needs. Whether limitations were real or simply perceived was not assessed. However, given that doctors reported making many decisions on the basis of acquired professional experience, which might not always be evidence-based, such beliefs may have influenced doctors' decision-making. Therefore, communities should develop modern informatics systems for rapidly disseminating information – across a healthcare network – to eldercare professionals. This information on community services should be relevant, objective and current [22,23].

## Conclusion

Physicians' interest in assisting caregivers in eldercare may be limited by lack of knowledge or confidence in community resources, or by insufficient skills in conflict resolution. In this study the difficulties reported by physicians regarding the content or process of the encounter with caregiver and elderly care-receiver suggest that doctors may have less power or control in the doctor-patient relationship than patients usually presume. Thus there is opportunity for expanded creativity in this triadic encounter as well as potential for more sharing with patient and caregiver regarding some of the dilemmas perceived [24]. Addressing these issues will most likely reduce the burden of care of the elderly for caregiver and physician alike.

## References

1. Stone R, Cafferata GL, Sangl J. Caregivers of the frail elderly: a national profile. *Gerontologist* 1987;27:616–26.
2. Navaie-Waliser M, Feldman PH, Gould DA, Levine C, Kuerbis AN, Donelan K. The experiences and challenges of informal caregivers: common themes and differences among whites, blacks, and hispanics. *Gerontologist* 2001;41:733–41.

3. Coe RM, Prendergast CG. The formation of coalitions: interaction strategies in triads. *Soc Health Illness* 1985;7:236-47.
  4. Adelman RD, Greene MG, Charon R. The physician-elderly patient-companion triad in the medical encounter: the development of a conceptual framework and research agenda. *Gerontologist* 1987;27:729-34.
  5. Physicians and family caregivers. A model for partnership. Council on Scientific Affairs, American Medical Association. *JAMA* 1993;269:1282-4.
  6. Green MG, Majerovitz SD, Adelman RD, Rizzo C. The effects of the presence of a third person on the physician-elder patient medical interview. *J Am Geriatr Soc* 1998;42:413-19.
  7. Toon PD, Southgate LJ. The doctor, the patient, and the relative: an exploratory survey of doctor-relative relationships. *Fam Pract* 1987;4:207-11.
  8. Cohen CA. Caregivers for people with dementia: what is the family physician's role? *Can Fam Phys* 2000;46:376-80.
  9. Schulz R, Beach SR. Caregiving as a risk factor for mortality: The Caregiver Effects Study. *JAMA* 1999;282:2215-19.
  10. Brotman SL, Yaffe MJ. Are physicians meeting the needs of family caregivers of the frail elderly? *Can Fam Phys* 1994;40:679-85.
  11. Alzheimer's Disease Study. Communication gaps between primary care physicians and caregivers. Washington DC: American Alzheimer's Association, May 2001.
  12. Forster A, Young J, Smith J, Knapp P, House A, Wright J. Information provision for stroke patients and their caregivers (Cochrane Review). In: *The Cochrane Library*. Oxford: Update Software, 2000:Issue 2.
  13. Brown JB, Brett P, Stewart M, Marshall JN. Roles and influence of people who accompany patients on visits to the doctor. *Can Fam Phys* 1998;44:1644-50.
  14. Dillman DA. *Mail and Telephone Surveys: The Total Design Method*. New York: John Wiley & Sons, 1978:119-99.
  15. Botelho RJ, Lue BH, Fiscella K. Family involvement in routine health care: a survey of patients' behaviors and preferences. *J Fam Pract* 1996;42:572-6.
  16. Yaffe MJ. Implications of caring for an aging parent. *Can Med Assoc J* 1988;138:231-5.
  17. Tansella CZ. Illness and family functioning: theoretical and practical considerations from the primary care point of view. *Fam Pract* 1995;12:214-20.
  18. Mace NL, Rabins PV. *The 36-Hour Day. A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illnesses, and Memory Loss in Later Life*. Baltimore, MD: Johns Hopkins University Press, 1981:27.
  19. Yaffe MJ, Stewart MA. Patients' attitudes to the relevance of nonmedical problems in family medicine care. *J Fam Pract* 1986;23:241-4.
  20. Fish JS, Steinert Y. Helping physicians in distress. Developing a physician assessment and referral service. *Can Fam Phys* 1995;41:249-55.
  21. Reust CE, Mattingly S. Family involvement in medical decision making. *Fam Med* 1996;28:39-45.
  22. Dulka I, Yaffe MJ, Goldin B, Rowe WS. Use of senior volunteers in the care of discharged geriatric patients. *J Soc Social Welfare* 1999;26:69-85.
  23. Rowe WS, Yaffe MJ, Pepler C, Dulka IM. Variables impacting patients' perceptions of discharge from short-stay hospitalization or same day surgery. *J Health Soc Care Commun* 2000;8:362-71.
  24. Baird MA, Doherty WJ. Risks and benefits of a family systems approach to medical care. *Fam Med* 1990;22:396-403.
- 
- Correspondence:** Dr. M.J. Yaffe, Family Medicine Centre, St. Mary's Hospital Centre, 3830 Lacombe Avenue, Montreal, Quebec, Canada, H3T 1M5  
Fax: (1-514) 734-2602  
email: mark.yaffe@mcgill.ca