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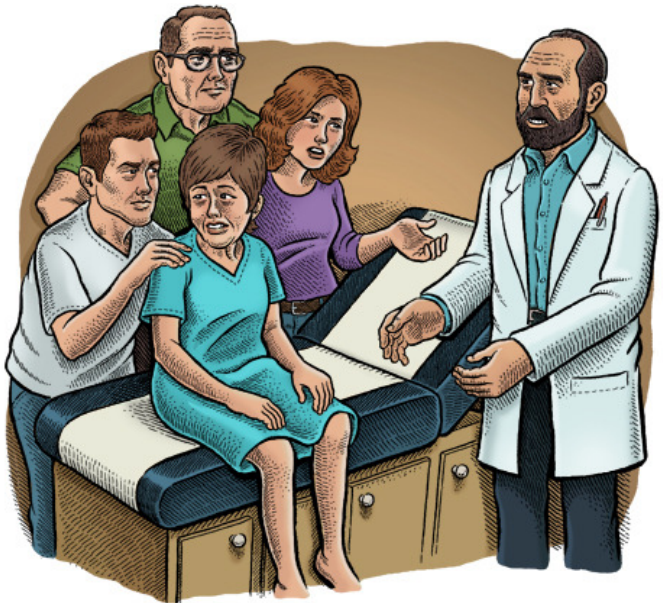

[Illustration by Mario Zucca / www.mariozucca.com]

When the office visit is a family matter

With patients' permission, relatives can play an active role in the exam room. But don't let them take over.

By KEVIN B. O'REILLY, amednews staff. *Posted Nov. 14, 2011.*

As a geriatrician who treats many patients with cognitive problems, Lee A. Lindquist, MD, MPH, is accustomed to seeing family members accompany patients on visits to her Chicago clinic. The relatives often serve as caregivers and help make critical medical decisions.

Yet Dr. Lindquist was taken aback when she walked into an exam room recently to find her patient waiting -- along with seven family members.

"It was like being in a crowded elevator," says Dr. Lindquist, assistant professor of medicine at Northwestern University Feinberg School of Medicine in Illinois. "We had a wheelchair in there, too, that the patient was sitting in. They all wanted to be in there, so we did it."

With relatives in the room, it proves difficult to keep the office visit focused, Dr. Lindquist says.

"It becomes more about managing family affairs than about what's best for the patient," she says. "I have to say, 'Stop! We're here for your mom.' It's kind of like how I treat my toddlers."

While squeezing seven relatives and a patient into one exam room is highly unusual -- if not physically impossible at most physician offices -- it is an extreme example of the family involvement in patient care that occurs every day.

One-third of physician visits include at least one family member in the exam room, according to a study of 138 physician practices in the May 1998 *Journal of Family Practice*. Even as the push toward the patient-centered medical home stresses the invaluable role that families can play in improving compliance and health outcomes, the presence of a relative raises a host of complicated issues for physicians to navigate.

"Now you've got potentially two patients in the room," says Jason Karlawish, MD, professor of medicine and medical ethics at the University of Pennsylvania School of Medicine. "You even have a kind of third patient, which is the relationship between the family member and the patient. If you ignore that, you ignore it at your own peril."

Avoiding assumptions

The first step to ensuring that relatives help rather than hinder care is to find out who they are and whether their

presence is OK with the patient, says Yul Ejnes, MD, a Cranston, R.I., general internist in private practice.

"You do not want to automatically bring in the spouse or the children or the parents without first getting the patient's permission," says Dr. Ejnes, chair of the American College of Physicians' Board of Regents.

Families are as varied as patients, says Edith Fresh, PhD, a psychologist and associate professor of clinical family medicine at Morehouse School of Medicine in Georgia. "We don't always know what the family dynamics are," she says. "Some families are not very intimate and don't share a lot. For that reason, the patient may prefer that the family member not be there. Meanwhile, the family member may feel that the only way they find out anything is to be in the exam room there with them."

Reid Blackwelder, MD, is well aware of the danger of making assumptions. "I walked in one day and saw an older man and a younger woman," says Dr. Blackwelder, professor of family medicine at Quillen College of Medicine at East Tennessee State University. "I blundered into not recognizing that the woman was his wife -- I thought she was his daughter. Now I always say, 'Hi, and you are ... ?' Then I ask the patient's permission to discuss medical issues in front of whoever the person is."

The next step to making the interaction with patients' relatives a positive one is to assess why they came along, says Dr. Karlawish, a geriatrician. "Ask questions," he says. "Just as you ask the patient for their chief complaint, you can turn to the family member and say, 'And you, is there anything in particular that you wanted to bring up?' They might say, 'I'm really concerned about my mother and her pain, and I'm worried that she doesn't want to tell you about it.'

"Asking gives them the safe space to give their own chief complaint, an agenda that they want to push forward," he says.

Foloshade S. Omole, MD, addresses the family member early in the visit. "I'm direct," says Dr. Omole, assistant chair of the Dept. of Family Medicine at Morehouse. "I say, 'Tell me why you're here today. What are you expecting to get out of your presence here?' "

Understanding the family member's role -- which can range from simple emotional support to taking a major part in medical decision-making -- can help shape the visit and the rest of the relationship with the patient, she says.

"You want to include them," Dr. Omole says. "I'll throw in a joke: 'What has the patient been saying about me?' Some people come just to observe the interaction between the physician and their loved one."

Even relatives who assume more of an observational role may express themselves without saying a word, says Dr. Blackwelder, a member of the American Academy of Family Physicians' board of directors.

"There are people who sit back and don't say anything," he says. "But they have their arms crossed, they're not smiling, they're not engaged with me, they're shaking their head. I'd stop in the middle and say, 'I'm not sure I'm connecting with you. You look angry, or confused. What's going on?' That helps keep me in touch with what they're thinking."

Dr. Lindquist also pays close attention to nonverbal communication. "Eye contact is important," she says. "If people are not looking you in the eye, they are not happy with what's going on and they are not trusting you. As a physician, I'm constantly trying to keep eye contact with everyone in the room so they don't come at me later with questions or concerns."

Setting boundaries

Acknowledging relatives and encouraging them to participate in the visit may be good practice, but experts say physicians should not allow them to distract from the patient. Though private time with the patient may not be needed at every visit, it is important to squeeze in some alone time so that the patient feels free to discuss potentially embarrassing problems or concerns.

This is especially true when any kind of patient abuse is suspected, or for older pediatric patients.

American Academy of Pediatrics policy says patients 11 and older should have a chance to speak privately with their physicians. Sometimes it can be hard for parents to allow that, as Dr. Omole knows first-hand. She has been caring for a female patient, now 21, since girlhood.

"The mother said, 'I'm the one paying all the insurance. I need to know what's going on,' " says Dr. Omole, who finally persuaded Mom to wait outside. "The mother was under the assumption that the girl was not sexually active. But the daughter told me in private that she was. I needed her to be alone for her to tell me that. ... How could I have asked her certain questions with her mother there, looking and listening?"

Keeping the patient front and center

Meanwhile, relatives sometimes dominate the visit, answering questions on behalf of mentally competent patients or diverting the focus.

"Sometimes the patient may not be talkative and the family members are, and you want to be sure not to cut the patient out of the conversation," Dr. Ejnes says. "You don't want it to become the family members' visit rather than the patient's visit."

And some relatives attempt to use the physician as leverage in settling a dispute about medical decisions or lifestyle

choices. "There are times I wonder whether I should be wearing a referee's shirt in the exam room," Dr. Ejnes says. "There are some family dynamics where the patient or the family member [tries] to draw the physician in as a third party in so-called triangulation. You have to be aware of that and not get sucked into that. It's not our place to be the referee on issues between the parent and the children or between spouses."

Dr. Karlawish tries to draw a clear line in adjudicating disagreements.

"If someone asks me for my medical judgment, I'll give them my view," he says. "But if I feel like I'm being drawn into a fight, I'll address that issue.

"I'll say, 'I sense some tension over this issue. Let's talk about that before we get to making a decision.' ... I will very much emphasize that my role is not as a family therapist."

Relatives who see themselves as advocates for their loved one's care may push physicians on treatment choices. Doctors should understand what is driving such conflicts, Dr. Blackwelder says.

"I have to advocate for the patient and take care of that relationship," he says. "It may be that the family member researched something on the Internet and believes that a particular test or treatment is needed and I don't happen to agree. I try very hard to say, 'I see you feel strongly about this' -- to see the emotion underlying it, often fear. They're not after a test or a treatment; it's an answer they want."

Families can be critical in helping patients keep physician appointments, adhere to medication regimens or live healthier lifestyles, experts say. And in the exam room, they can help give more accurate histories, take notes and ask important questions. But relatives should not be allowed to detract from the value of the patient's time at the doctor's office.

"The biggest mistake that can be made is to forget that the patient is the boss," Dr. Ejnes says.

"It's helpful to have family involved, but everything needs to be done with the consent of the patient, while respecting their values and making sure they're at the center of all of this. Everyone else is an accessory. If you forget that, then you're not really communicating with the patient in that exam room."

Dr. Omole, of Morehouse, agrees. "Family members are important in the care that you're going to render to your patients," she says. "But we need to be able to juggle it so that you're not focusing on the family member's needs rather than the patient's needs."

ADDITIONAL INFORMATION:

How to balance needs of patients and their families

About 42 million Americans help relatives with doctor visits and managing medications. Such involvement can pose ethical challenges for doctors, says the American College of Physicians' Ethics, Professionalism and Human Rights Committee. The panel advises doctors to:

- Focus clinical encounters on the patient, allowing for maximum appropriate patient autonomy and participation in decision-making.
- Routinely assess the patient's wishes regarding the nature and degree of family participation in the clinical encounter and strive to provide the patient's desired level of privacy.
- Strive to ensure that the patient, family caregiver and other relatives have a common, accurate understanding of the patient's conditions and prognosis.
- Encourage discussion of the patient's health care values and advance care planning so the family caregiver and physician have a clear understanding of the patient's wishes.
- Validate the relative's role and be sensitive to the specific commitments the caregiver may have made regarding how he or she will manage the patient's care.
- Watch for signs of distress in the family caregiver and suggest appropriate referrals.

Sources: "Valuing the Invaluable: 2011 Update -- The Growing Contributions and Costs of Family Caregiving," AARP, July; "Family Caregivers, Patients and Physicians: Ethical Guidance to Optimize Relationships," American College of Physicians Ethics, Professionalism and Human Rights Committee, 2009

How relatives shape care

Family members who prompt patients to talk or ask questions are four times likelier to take part in decision-making compared with relatives who silently observe a patient visit. Here are some other findings about relatives in the exam room:

- 93% of people accompanying patients into the exam room are family members.
- 75% of clinical encounters with a family member present are influenced by the relative.
- 60% of the time, relatives help physicians understand the patient, doctors say.
- 32% of patient visits to physicians include at least one relative in the exam room.
- 10% of the time during such visits is devoted to addressing family issues.

Sources: "Autonomy-related behaviors of patient companions and their effect on decision-making activity in geriatric primary care visits," *Social Science & Medicine*, April 2005; "The third person in the room: Frequency, role, and

influence of companions during primary care medical encounters," *The Journal of Family Practice*, August 2002; "The family in family practice: is it a reality?" *The Journal of Family Practice*, May 1998

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"Valuing the Invaluable: 2011 Update -- The Growing Contributions and Costs of Family Caregiving," AARP, July (**www.aarp.org/relationships/caregiving/info-07-2011/valuing-the-invaluable.html**)

"Family Caregivers, Patients and Physicians: Ethical Guidance to Optimize Relationships," American College of Physicians Ethics, Professionalism and Human Rights Committee position paper, 2009 (**www.acponline.org/running_practice/ethics/issues/policy/caregivers.pdf**)

"Autonomy-related behaviors of patient companions and their effect on decision-making activity in geriatric primary care visits," *Social Science & Medicine*, April 2005 (**www.ncbi.nlm.nih.gov/pubmed/15652689**)

"The third person in the room: Frequency, role, and influence of companions during primary care medical encounters," *The Journal of Family Practice,* August 2002 (**www.ncbi.nlm.nih.gov/pubmed/12184964**)

"The family in family practice: Is it a reality?" *The Journal of Family Practice,* May 1998 (**www.ncbi.nlm.nih.gov/pubmed/9597996**)

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