

11-1-2002

# The roles of companions in geriatric patient–interdisciplinary oncology team interactions

Laura L. Ellingson  
Santa Clara University, [lellingson@scu.edu](mailto:lellingson@scu.edu)

Follow this and additional works at: <https://scholarcommons.scu.edu/gender>



Part of the [Communication Commons](#), and the [Feminist, Gender, and Sexuality Studies Commons](#)

---

## Recommended Citation

Ellingson, L. L. (2002). The roles of companions in geriatric patient–interdisciplinary oncology team interactions. *Journal of Aging Studies*, 16(4), 361–382.

© 2002. This manuscript version is made available under the CC-BY-NC-ND 4.0 license <http://creativecommons.org/licenses/by-nc-nd/4.0/>.

Final version can be found at:

[http://dx.doi.org/10.1016/S0890-4065\(02\)00071-3](http://dx.doi.org/10.1016/S0890-4065(02)00071-3)

This Article is brought to you for free and open access by the College of Arts & Sciences at Scholar Commons. It has been accepted for inclusion in Women's and Gender Studies by an authorized administrator of Scholar Commons. For more information, please contact [rscroggin@scu.edu](mailto:rscroggin@scu.edu).

The Roles of Companions in Geriatric Patient-Interdisciplinary Oncology Team Interactions

Submitted by  
Laura L. Ellingson, Ph.D.  
Assistant Professor of Communication  
Santa Clara University

**Until July 25, 2001 please contact at**

220 South Glen Ave  
Tampa, FL 33609  
Phone: (813) 871-5086  
Email: [lellings@luna.cas.usf.edu](mailto:lellings@luna.cas.usf.edu)

**After July 25, 2001 please contact at**

Department of Communication  
Santa Clara University  
Arts & Sciences Bldg., Rm. 229  
500 El Camino Real  
Santa Clara, CA 95053  
Phone: (408) 554-2798  
Fax: (408) 554-4913  
Email: [lellingson@scu.edu](mailto:lellingson@scu.edu)

Submitted to

Dr. Jaber F. Gubrium, Editor,  
Journal of Aging Studies  
Department of Sociology  
University of Florida  
P.O.Box 117330  
Gainesville, FL 32611-7330

Acknowledgments: The author would like to thank Dr. Marsha Vanderford for her feedback on earlier drafts of this paper. Earlier versions of this paper were presented at the 2000 National Communication Association convention and the 2000 NCA Doctoral Honors Seminar.

## Abstract

## The Roles of Companions in Geriatric Patient-Interdisciplinary Oncology Team Interactions

This study examined companions' roles in interactions between patients and interdisciplinary geriatric oncology team members. Companions' roles identified include: memory aid, emotional support, transcriber, aid in decision making, companionship, elaboration, advocate for patient, and interpreter. Specific patterns of variability of roles across team member disciplines include: relatively passive companions who performed more active roles with physician; relatively active companions who performed more passive roles with physician; and relatively passive companions who performed more active roles when particular topics were raised, regardless of team discipline. Two patterns of stability across interactions emerged: consistently active or passive.

Reviews of health communication literature have found that patients' companions play vital roles in patient-health care provider interactions (Haug, 1996; Thompson, 1994). The presence of a companion is normative among oncology patients (Beisecker & Moore, 1994), and older patients are more likely to bring a caregiver or companion than are younger patients (Adelman, Greene, & Charon, 1987; Beisecker, 1988, 1989, 1996). Since sicker patients are more likely to bring a companion to a visit, age differences disappear in serious illnesses such as cancer (Beisecker, 1996; Labrecque, Blanchard, Ruckdeschel, & Blanchard, 1991). Thus, in a geriatric oncology setting, where the patients are both old and often quite sick, the vast majority of patients bring a friend or relative of some sort with them (Beisecker & Moore, 1994).

The presence of a third person has significant impact on the interaction between patient and health care provider. The companion may inhibit or enhance patient-physician encounter (or both), and is likely to play multiple roles during a single visit (Adelman et al., 1987; Beisecker, 1989; Beisecker & Moore, 1994). Much of the writing about the role of companions has been in essays and book chapters that are speculative and exploratory, rather than reporting the results of a program of research (e.g., Beisecker, 1996; Haug, 1996; Rosow, 1981). Recently, empirical research addressing the roles of companions and caregivers in physician-patient interaction has offered a better understanding of the opportunities and challenges of this important component of interactions. Research has focused on physician-patient communication, despite the fact that older patients are likely to interact with a wide range of health care providers (Haug, 1988). In this study, I further the empirical research conducted into this area by examining the roles of companions within interactions between geriatric patients and health care providers representing a variety of disciplines in an interdisciplinary geriatric oncology clinic.

I will begin with a brief survey of communication issues in the health care provider-geriatric patient interaction, describe specific findings on the roles of companions in physician-patient interactions, and examine research on communication between geriatric teams and patients.

### Review of Literature

#### Communication Issues with Geriatric Patients

To contextualize the impact of the companion on the interaction, it is helpful to consider some of the more pressing communication issues in geriatric patient-health care provider interaction. The elderly are the fastest growing segment of the U. S. population, with elderly women forming the majority of this group (Allman, Ragan, Newsome, Scoufos, & Nussbaum, 1999). On average, senior adults make more visits to physicians per year than younger patients (Beisecker, 1996). Visits with older patients differ in significant ways from physician interactions with younger patients (Adelman et al., 1987). A number of communication issues are particularly pertinent to communication with geriatric patients.

First, older patients are more likely to have impairments in hearing, vision, cognition, and function that affect communication than younger patients (McCormick, Inui, & Roter, 1996; Ryan, Meredith, & MacLean, 1995). Because of the potential challenges to good communication, older patients are at higher risk for misunderstandings with physicians (Allman, et al., 1999; Beisecker, 1996).

Second, ageism, a form of discrimination against old people, appears to play a significant role in health care provider-older patient interactions. Many physicians are biased against older people and this affects their communication and treatment decisions (Adelman, Greene, Charon, & Friedmann, 1990; Beisecker, 1996; Ford & Sbordone, 1980; Haug, 1988, 1996; McCormick, Inui, & Roter, 1996). Ageism may cause physicians to discount certain complaints of older patients, to ignore treatable conditions mistakenly attributed to normal aging, and to fail to recognize that some

diseases manifest differently in older patients than in younger ones (Adelman, Greene, Charon, & Friedmann, 1990; Lefer, 1981). Adelman, et al. (1990) found that physicians were less egalitarian, less patient, less engaged, less respectful, less likely to raise psychosocial issues, provided poorer quality information on physician-raised topics, and were less supportive in discussions of patient-raised topics with older patients than with younger patients. Often physicians make unwarranted assumptions about older patients' loss of function (Hasselkus, 1994)<sup>1</sup>.

Cohort socialization also impacts geriatric patient-health care provider interactions. Older patients are often reluctant to express complaints, confusion, disappointment, or misunderstanding and are more likely to express gratitude (Bremhaar, Visser, & Kleijnen, 1990). Older patients are more passive in interactions with physicians (Beisecker, 1996), often seeming to prefer that physicians make decisions without their active involvement (Beisecker, 1988, 1996; Haug, 1988). One study on elderly patients found that patients tended to conceive of themselves as "junior partners" to their health care providers, desiring information but wanting the physician to retain primary decision making power (Owens & Batchelor, 1996). This cohort effect may change as increasingly educated people age and join the ranks of the elderly (Haug, 1988, 1996).

Of course, patient age does not exist in a vacuum. factors such as race, gender, and class intersect with age and affect communication and physicians' treatment decisions (Beisecker, 1996; Clark, Potter, & McKinlay, 1990; McCormick, et al., 1996). Differences in ethnicity, language, levels of education, and religious and cultural beliefs may make provider-patient relationships more problematic (Haug, 1988, 1996; Haug & Ory, 1987; Rosow, 1981; Ryan, et al., 1995). Some research suggests that physicians may be particularly biased against African Americans (e.g., Clark, et al., 1990). Class is also a crucial factor in physician-patient communication. Physicians tend to give less time and less complete information to people of lower socioeconomic classes (Pendleton & Bochner, 1980). Twice as many ethnic minority older people live below the poverty line than do

older white people, and they are more likely to be devalued and receive poorer care than those in higher socioeconomic classes (Jackson & George, 1998).

Patient gender is another crucial factor to consider. Research indicates that physicians often do not listen to women carefully and take women's concerns less seriously than men's (Borges & Waitzkin, 1995; Fisher, 1984, 1986; Gabbard-Alley, 1995). The intersection of old age with gender may make patients especially vulnerable; older women are at greater risk than men for abuse and inequities in health care delivery (Allman, et al., 1999)<sup>2</sup>.

Finally, physician attitudes towards older patients also are mitigated by health status. Physicians perceive healthier patients as more likable than sicker patients (Hall, Epstein, DeCiantis, & McNeil, 1993) and give sicker patients less social talk (Bertakis, Callahan, & Helms, 1993). Since older patients often are sicker than younger patients, physicians may be predisposed to like them less, even if they don't hold negative, ageist views of senior adults per se.

All of these factors contribute to the context in which the geriatric patient-health care provider interaction takes place and in which patients' companions participate. Keeping in mind the many barriers to good communication that older patients and their health care providers face, I now turn to research specifically on the roles patients' companions and caregivers play in such interactions.

### Companions in Physician-Patient Interaction

The role of companions in provider-patient interactions is particularly relevant in geriatric settings. As explained earlier, the vast majority of geriatric oncology patients are accompanied to their appointments with physicians. In general, companions are most likely to be spouses, parents, siblings, and adult children (Beisecker & Moore, 1997). Married patients are generally accompanied by spouses (78%) (Labrecque et al, 1991). Elderly patients generally bring family members (Beisecker, 1989), most likely daughters or wives (Haug, 1988, 1996). More than one

companion may be present, which makes the interaction exponentially more complex (Glasser, Rubin, & Dickover, 1990; Hasselkus, 1994).

Typologies of Roles. Several studies of the role of companions in the physician-patient interaction offer typologies of roles or behaviors performed by companions. Research variously reflects the perceptions of patients, companions, physicians, and researchers.

Research that assessed patients' perceptions found that patients reported three primary roles of the companion: advocate (patient promoter, patient extender, or patient-doctor mediator), passive participant, or antagonist (saboteur or opportunist) (Adelman, et al, 1987). Similarly, patients in Prohaska and Glasser's (1996) study cited transportation, physical assistance, emotional support, and making sure patients understand treatment and prescriptions as primary roles for companions. Generally, patients appear to value companion presence and involvement in interactions with physicians. Patients and companions reported that they found companion presence helpful and satisfying (Beisecker et al., 1996; Prohaska & Glasser, 1996).

Companions' views of their roles closely parallel those of patients. Companions of cancer patients reported that they provide support and companionship, increase patient understanding, ask questions, and furnish transportation (Beisecker, Brecheisen, Ashworth, & Hayes, 1996). Some research has examined the perspectives of companions who are also family caregivers for the patient. Caregivers report that they want support and acknowledgment of their roles from the medical community; better explanations of patient's conditions; and assistance in coping through offering information and hope (Glasser, et al., 1989). Caregivers report less satisfaction than do patients with physicians' behaviors including amount of information provided, emotional support offered, degree of control exerted by the physician, and assistance with obtaining referrals to health care services (Glasser, et al., 1989; Haley, Clair, & Saulsberry, 1992). Compliance with treatment is often more dependent upon caregivers' understanding and cooperation than that of older patient

because the caregiver often must carry out the treatment or administer the drugs prescribed by the physician (Beisecker, 1996; Wieder, 1994). Caregivers frequently reject physician recommendations that conflict with their knowledge based on extensive experience with the patient (Hasselkus, 1994; Haug, 1996). Companions who are also caregivers (which is often the case with geriatric oncology patients) thus have expectations of both their own roles and those of physicians that significantly affect the physician-patient interaction.

Physicians reported the effect of the companion's presence as generally favorable. Advantages of companion presence include: companions support and encourage patients; assist in decision making; help patients to verbalize, ask questions, and voice concerns; provide information to the physician; and interpret information for the patient (Beisecker & Moore, 1994). The physician-companion coalition is often more efficient than keeping patients more actively involved in decision making; physicians value this because of time pressures (Rosow, 1981). Physicians perceived that drawbacks of companion presence include: companions express their own fears, rather than patients'; it takes time to address the companions' questions and needs; companions may manipulate the situation or the patient; companions may have their own agenda; and companions' behavior may be antagonistic or adversarial (Beisecker & Moore, 1994, p. 30).

Other studies focused on researchers' perspectives of how companions functioned in interactions, rather than the perceptions of the participants in patient-companion-physician interactions. In an exploratory essay, Rosow (1981) speculated that adult children accompanying their parents to visits with physicians act as interpreters of language, facilitate the exchange of factual information, explain and clarify meaning for both physician and patient, participate in negotiation of treatment, and provide emotional support to patients. Based upon analysis of taped interactions between physicians and patients, Beisecker (1989) argues that companions may act as watchdog (provided further information for doctor, clarified or obtained information from doctor,

challenged the truth of information offered by patient), significant other (provided doctor feedback on role behavior and often caused doctor to shift direction of comments to companion rather than patient), or surrogate patient (took over patient role, interrupted patient, answered questions for patient and provided unrequested information to health care provider). Another study summarized companion roles as medication managers, interpreters, negotiators, or caretakers (Coe & Prendergast, 1985). Hasselkus (1992) found that companions acted in two primary roles: the “interpreter” participates in the interaction by correcting, adding to, prompting, answering for, and paraphrasing patient’s comments, which may signal to physicians patients’ need for assistance (whether real or not); the “second practitioner,” particularly when patients have marked impairments, tends to interact with the physician as another practitioner would, having extended dyadic communication with each other during history taking, decision making, and instruction giving (Hasselkus, 1992).

It is not clear whether companion involvement increases amount of time physicians spend with patients. Physicians in one study gave more information to patients accompanied by family members and spent more time with patients (Labrecque, et al., 1991). This finding contrasts with Beisecker’s (1989) finding that patients with companions received no more time than those without. Since the companions took some of the speaking time, the patients’ actually ended up with less time as individuals. Researchers note a number of other potential disadvantages of companion involvement. Greene, Majerovitz, Adelman, and Rizzo (1994) found that triadic encounters involving a companion were more likely than dyadic encounters to involve older patients raising fewer topics, being less assertive and expressive, engaging in less joint decision-making with physicians, sharing less laughter with physicians, and even frequent exclusion of the patient from the conversation. Coalitions may form in the physician-patient-caregiver encounter, and older patients may be ignored as physicians and caregivers make decisions (Coe & Prendergast, 1985;

Hasselkus, 1994; Haug, 1988; Prohaska & Glasser, 1996; Rosow, 1981). Presence of companion may trigger assumptions of patient incapacity (Hasselkus, 1994). Patient permission is usually not directly sought for the companion's presence to continue throughout the interaction with the physician, and this raises ethical issues about privacy and patients' rights (Adelman et al., 1987).

Given this range of roles and effects of companions in interactions, it is useful to see whether similar roles and function emerge in a geriatric oncology team setting.

RQ: What roles do companions play in the geriatric oncology patient-interdisciplinary team member interaction?

### Geriatric Team Care

The study also broadens the focus from physician-patient interaction to interactions between interdisciplinary health care providers and patients. Interdisciplinary teams have become prevalent in health care delivery, particularly in the field of geriatrics (Abramson & Mizrahi, 1996; Cooley, 1994; Lichtenstein, Alexander, Jinnett, & Ullman, 1997; Wieland, Kramer, Waite, & Rubenstein, 1996). Increased specialization contributes to the need for collaboration between experts in different areas of knowledge (Cooley, 1994; Satin, 1994; Stahelski & Tsukuda, 1992). Geriatric evaluation teams are extremely effective at assessment and intervention (McCormick, et al., 1996; Rubenstein, Josephson, & Wieland, et al., 1984). Careful assessment and coordination of treatment and services are especially important for older patients because this population is more likely than others to have multiple health needs, as well as complex interactions of medical, psychosocial, and material circumstances (Satin, 1994; Siegel, 1994; Stahelski & Tsukuda, 1990). Older patients are likely to have fragmented care, seeing a different specialist for each chronic or acute conditions, thus greatly increasing the need for coordination of care (Beisecker, 1996).

The interdisciplinary team-patient relationship differs from the dyadic physician-older patient relationship both positively and negatively. Team care may provide more autonomy for

patients and less intense one-on-one relationships with individual health care providers (Siegel, 1994). With a team, patients are able to direct concerns to team members with whom they are more comfortable, and they may feel less dependent upon a single health care provider. On the other hand, patients may feel uncertainty about which team member to contact for a particular issue, repetition of history and multiple visits may be necessary, and patients may give conflicting information to different team members, causing confusion (Siegel, 1994). Even though information is gathered and assistance given to patients by multiple team members from varying disciplines, the information and assessments gathered and formulated by these team members also are part of and integral to the physician-patient interaction and affects satisfaction of both physician and patient (McCormick, et al., 1996; Miller, Morley, Rubenstein, Pietruszka, & Strome, 1990). Physicians depend upon the data and opinions of other team members in making treatment decisions.

As mentioned earlier, researchers have found that the companions' roles shift over the course of a single interaction with a physician. It logically follows that companions' roles will shift within and between interactions with members of an interdisciplinary oncology team meet with patients' and their companions during the patients' initial assessment. Given that existing research has focused on interactions with physicians, the potential ways in which the discipline of the health care provider influences companions' involvement in interactions is unknown. Patients and companions do not perceive of all health care providers as equal or similar; their attitudes about physicians are often different from those expressed about members of other disciplines. Since geriatric patients are likely to interact with multiple (nonphysician) members of teams in a variety of health care settings (e.g., Beisecker, 1996), it would be helpful for members of health care teams to know if companions' roles shift according to discernible patterns that relate to the discipline of the team members. Such information could prove valuable in identifying and improving communication problems with triadic patient-companion-health care provider interactions.

RQ<sub>2</sub>: How do companions' roles shift or remain stable across discipline of the members of the geriatric oncology team?

## Method

### Setting and Participants

This exploration of the roles of companions is part of a larger study of communication within an interdisciplinary geriatric oncology team (Ellingson, 1998, 2001). In the two plus years I observed the team, only a handful of patients came to the clinic without at least one companion<sup>3</sup>, indicating that companions are central to geriatric patient-health care provider communication. The team included two oncologists, a nurse practitioner, a clinical pharmacist, a registered dietitian, two registered nurses, a licensed clinical social worker, and an administrative assistant. Each new patient was seen by the entire geriatric oncology team on her or his first visit for a comprehensive geriatric assessment (Rubenstein, Stuck, Siu, & Wieland, 1991). After the recording of vital signs by a nursing assistant, a brief "orientation" to the team process was done by a registered nurse to answer any questions patients and companions had about the literature sent to them about the program before their visit<sup>4</sup>. The nurse practitioner, dietitian, social worker, and pharmacist then cycled through patients' rooms, in no particular order. After each of these professionals completed her assessment, the dietitian, social worker, and pharmacist reported their findings, concerns, and interventions to the nurse practitioner, who in turn reported this information and the results of her history taking and physical exam to the oncologist. The nurse practitioner accompanied the oncologist into the examination room, where the doctor made treatment recommendations to the patient and companions. Finally, the registered nurse returned to discharge the patient, providing prescriptions, paperwork, contact information, and instructions. The entire process generally took two to three hours.

The data used for this study consisted of two primary sources: ethnographic field notes and transcripts.

Ethnographic field notes. I assumed the “participant-as-observer” position in my fieldwork (Lindlof, 1995), spending three to five hours one day per week in the “new patient” clinic and one hour per week in the team’s weekly meeting at a regional cancer center in the southeastern United States. Clinic observation was conducted weekly from September 1997 through December 1999. With permission, I observed interactions between patients, companions, and team members; occasionally helped out with minor tasks (e.g., getting patient a glass of water); and talked with patients, companions, and team members. While in the clinic, I kept a notebook or a “palmtop” computer at the desk area, in which I wrote brief notes. Immediately after observing, I typed extensive field notes detailing my observations, ultimately producing more than 300 pages of notes.

Transcripts. To supplement the field notes, I also completed and transcribed nine audio recordings of initial patient visits from May through July 1999. Following an Institutional Review Board approved protocol, patients were approached in the waiting room and asked to participate. Those who agreed had the informed consent forms explained to them and had any questions answered before signing. I was present during all of the interactions between patients, companions, and geriatric team members in order to monitor the equipment. Except for a few times when directly addressed by patients or companions, I did not participate in the audiotaped interactions<sup>5</sup>. The recordings included interactions between patients, companions, and each of the geriatric oncology team members. The interactions were transcribed, and the transcripts used as data for this study.

### Data Analysis

Using grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1998) I analyzed the field notes and transcripts. Researchers such as Beisecker, et al. (1996), and Beisecker

and Moore (1994) have used grounded theory methodology for studies of companions in physician-patient interactions because it enabled them to identify and categorize behaviors inductively rather than imposing pre-existing typologies that were developed using dissimilar data. Careful exploration of data through inductive analysis may help to avoid making assumptions based on research with physician-patient dyads that do not accurately explain the dynamics in patient-companion-physician interactions. In extending prior research on companions' roles from physician-patient interactions into an interdisciplinary geriatric oncology setting, I found that the complexity of the communication with patients and companions was exponentially complicated by the number of health care providers and the diverse disciplines they represented. Thus I concurred that the data could best be explored through grounded theory analysis.

To develop categories of roles and identify patterns of variation and stability, I compared interactions contained in the field notes and transcripts, noting similarities and differences in content and structure of interactions between patients, companions, and health care providers. I developed preliminary categories based on similarities I observed across interactions and continually refined the typology as I reread the transcripts; this is the constant comparative analysis process (Charmaz, 2000). After determining the variety of roles played by companions, I returned to the data to search for patterns of variability and/or stability across the discipline of the health care provider. Patterns were derived inductively in the same manner as the role categories.

## Results and Discussion

### Roles Played by Companions

Overall, the roles of companions in the setting studied are very similar to the roles reported by other researchers (Beisecker, 1989; Coe & Prendergast, 1985; Hasselkus, 1992). The most common functions served by companions include: memory aid, emotional support, transcriber, aid in decision making, companionship, elaboration, advocate for patient, and interpreter.

Companions who acted as memory aids recalled past events, symptoms, and information obtained from other health care providers. Dates of surgeries and hospitalizations were especially common facts provided by companions. Companions generally volunteered information when patients paused or seemed unsure of their answers, but they also provided information in response to direct requests from the patients. Geriatric team members seldom addressed questions directly to companions, except in the rare occasion that a patient had repeatedly been unable to answer questions posed to her/him. The function of memory aid was particularly prevalent among male patients who frequently turned to their wives for information or verification of facts.

Many of the companions provided emotional support to patients, offering empathy and expressing support verbally and nonverbally (e.g., holding patient's hand, putting an arm around patient's shoulders). Many patients came to the cancer center for a second opinion after they had been in treatment for awhile and/or to investigate experimental protocols when past treatments had failed. Thus patients were often frightened, sad, angry, frustrated, and losing hope, and they turned to companions and to health care providers for emotional support. Interestingly, many companions who offered support to patients also sought emotional support from health care providers, particularly wives and daughters who sought support from nonphysician team members.

Some companions, particularly adult children, acted as a transcriber, recording information on diagnosis, treatments, and recommendations, usually through written notes or occasionally using a tape recorder. Often these adult children did not reside close to their parents and felt that they were not getting sufficient second-hand information from their parents on prognosis and treatment options. Thus they accompanied parents to visits in order to gain information for themselves and often, they remarked, to share with siblings or other relatives. Interactions with transcribers frequently involved a patient, spouse, and adult child, forming a quadratic (rather than triadic) interaction.

Companions, particularly spouses, aided in decision making. They discussed options with patients and offered opinions and suggestions. Frequently the companion tried to alleviate fears or clarify information to convince the patient to consent to the treatment the health care provider recommended. Less often, companions encouraged patients to resist recommendations. This usually happened when a health care provider urged patients to discontinue high dose vitamin and herbal supplements that might interact with other drugs, or that put a financial burden on patients while offering no apparent benefit. Since companions or family members were often the initiators of such vitamin and herbal regimens, some resisted discontinuing them.

Because the initial visit is lengthy, many companions simply provided companionship and conversation to pass the time. Patients often spend fifteen minutes or more between visits with team members, and they understandably get bored, tired, and restless. Many patients and companions sought to engage me in conversation as I left the examination room after each segment of team visit, and a desire for companionship seemed to be the primary motivation.

Spouses were most likely of the various companions to provide elaboration. This is different from aiding in memory or recall of facts; often companions provided context for patient comments, elaborating with further information, impressions, and details. For example, when asked what he normally had for breakfast, a patient answered oatmeal and orange juice. The patient's wife then added that the patient had eggs about once or twice a week instead of the oatmeal, and also that he had a cup of coffee with breakfast every morning. The patient nodded and agreed that that was true, smiling at his wife. Clearly, the wife was trying to be helpful and the patient perceived it that way as well. Other times, elaboration involved contradicting the patient's impressions, or even controlling the encounter to the relative exclusion of the patient's perspective. It was not uncommon for a husband or adult child to answer for the patient or extend the patient's answer in a manner that reflected a controlling relationship. One female patient was asked if she

felt depressed. Looking somewhat frightened, she answered hesitantly that she did not think so. Her adult daughter immediately elaborated in a dismissive tone that her mother had always been prone to crying over nothing and that there was “nothing to worry about.” This caused concern among team members who suspected that the mother was being overly controlled or mistreated by the daughter. Yet other companions appeared to elaborate simply because they enjoyed having an attentive audience. One man, a romantic partner of a female patient, cheerfully described in minute detail every dish he had cooked for the patient in the last week and precisely how much of each she had eaten, despite numerous attempts by the dietitian to indicate that she already had sufficient information.

Some companions advocated for the patient, asking questions about other treatment options, expressing and supporting patients’ reluctance to undergo certain types of treatment (usually chemotherapy), or making requests on the patients’ behalf (such as requesting a sleeping pill). Sometimes the companion was responsible for the patient having come to the cancer center for a second opinion, either as a safeguard or because of dissatisfaction with another practitioner. In several instances, companions expressed frustration with other oncologists who had advised no further treatment, except for palliative care, and stated that they were looking for an oncologist who would treat the cancer aggressively. It often was difficult to discern when the desire to continue treatment or to explore other treatment options originated in the patient and when the patient was complying with the companion’s wishes.

Finally, the role of interpreter involved repeating things for hearing impaired patients, re-explaining concepts or options offered by a team member, and occasionally providing language translation. Very few patients with significant cognitive impairment or language barriers were present at the geriatric oncology clinic. In the majority of cases, interpreters clarified details of

treatment plans or answered questions from the patients regarding the meaning of medical terminology or complex instructions.

Overall, in the interdisciplinary oncology setting, the roles played by companions appear to be very similar to those in physician-patient interactions. The interdisciplinary team provided a comprehensive assessment of patients' physical and psychosocial status, and thus explored areas of patients' lives that companions in physician-patient interactions often did not discuss. Moreover, the initial visit with the geriatric oncology team was considerably lengthier than a visit with a physician. Despite these differences in interaction length and content, the general patterns of companion behavior appear relatively consistent with prior research findings.

#### Patterns of Variability and Stability of Companion Role Across Team Member Discipline

There were three general patterns of variability that were reflected in the data, as well as two relatively stable patterns of behavior across interactions. Companions ranged from being more actively involved when physician is present than with other team members; more submissive and less actively involved when physician is present than with other team members; or more active whenever the discussion centered on a particular issue regardless of which team member was present. The patterns of relative stability included companions who were consistently actively involved or consistently passive in the interactions with all members of the geriatric oncology team.

Variability. Some companions appeared to view the interactions with nonphysician health care professionals as relatively unimportant preambles to the physician visit. Consequently, they remained uninvolved in interactions with nonphysician team members unless directly asked a question. One adult son who accompanied his mother read business reports and a newspaper throughout his mother's interactions with team members, putting his reading aside and introducing himself only when the physician came into the room. On other occasions, companions actually physically left the examination room to stretch their legs or get something to eat, intending to return

when the physician arrived. Companions who physically or psychologically disengaged with the nonphysician team members may have perceived that because the other team members could not answer treatment questions, or provide certain types of information, that the information and interventions they did provide was of little use. Also there may have been a perception of relative status of the team members. People in the U.S. are still socialized to think of physicians as powerful authority figures (Brody, 1992), and the other team members may have seemed to play preliminary or insignificant roles compared to the physician. Some companions thus appeared to grant the other team members less legitimacy and simply declined to pay attention to them.

Other companions reacted in the opposite manner, becoming less animated, contributing less to the conversation, and asking fewer questions when the physician was present than when the other team members were present. Most likely this is another manifestation of socialization not to question the authority of physicians or take up “too much” of their time. Physician presence may have caused companions to become more attentive to the interaction, and yet be less willing to engage in more active roles. The reluctance to be an advocate, or pursue a specific agenda, did not appear to be a result of complete understanding or satisfaction with information presented by the physician. To the contrary, after the physician left, patients and companions not infrequently turned to me as I attended to the tape recorder and asked me to repeat information or to provide further explanation<sup>6</sup>. I also do not believe that the pattern of deference to the authority of the physician generally reflected a lack of respect for the nonphysician team members. Many patients and companions appeared to enjoy the comprehensive interdisciplinary assessment process, and often thanked the various professionals for talking with them, answering questions, and taking psychosocial concerns seriously. Rather, the respect for the nonphysicians was not accompanied by the same level of intimidation or fear of authority as these companions may have experienced with

the physicians. This pattern was particularly apparent with companions of the same generation as the geriatric patient (spouse, sibling, friend, or romantic partner).

Finally, a smaller number of companions appeared to become more active whenever a particular issue was raised, regardless of which health care professional raised the topic. This appeared to reflect a certain agenda of the companion. Two common issues that repeatedly prompted otherwise relatively passive companions to speak up (regardless team member present) were the need for sleeping pills and the perception that the patient suffered from depression. Since questions from all of the various team members could relate to these issues, there were multiple opportunities to discuss them. For example, the social worker asked about quality of life, and this often prompted patients to say they were tired and companions to elaborate that the patient did not sleep well at night. Then the dietitian may have asked about eating habits and have be told that the patient did not eat late in the evening because she had trouble sleeping and thought it may be related to what she ate. The nurse practitioner routinely asked about sleeping habits, and the pharmacist inquired about medications, again providing opportunities to discuss sleeping pills. Thus companions with a specific goal may have found several opportunities to pursue it, even if the companions remained disengaged at other times during the interaction, or confined their roles to providing emotional support or companionship to the patient.

Stability. In addition to these patterns of variability, there were two different patterns of relative stability that occurred with some companions across interactions with team members. Some companions remained highly active in the interaction regardless of discipline of the health care provider, while a small number remained consistently inactive across the interactions. The companions who were highly active throughout the interactions tended to aid in decision making, serve as a memory aid, and provide elaboration. At times this high level of involvement by the companion was helpful to patient and team member, and other times it was intrusive and

marginalized the patient. Many of the older couples who had been married for 40 years or more seemed extremely comfortable finishing each other's sentences and allowing the companion and patient to take turns answering questions and elaborating; such couples appeared to have an effective synergistic style. Other times, the companion (often a husband, but sometimes a wife or adult child) exerted a great deal of control over the interaction, such that team members felt that they were not getting a view of the patient's circumstances that reflected the patient's perspective. Older women companions who were wives of patients tended to take very active roles in questioning, elaborating, and aiding in decision making. Also, female companions much more than male companions actively sought emotional support from nonphysician team members (all of whom were female) in the course of questioning and assessment. In cases where the patient and companion appeared to be working synergistically, team members generally proceeded, allowing the companions to continue their active roles. When the companions' presence was judged intrusive, however, team often deliberately addressed questions directly to the patient, making eye contact with the patient and using his or her name in an attempt to circumvent the talkative companion.

The small number of consistently passive, disengaged companions may have seen their primary role as one of providing transportation or companionship for the long visit, particularly if they were a friend rather than a relative (although some friends were highly involved in the interactions). Passive companions were not completely ignored, however. The presence of the companion always was acknowledged by team members who introduced themselves to each person in the room, and if the companion was a family member, team members also generally asked if she or he had questions after giving the patient the same opportunity. The presence of the companion may also have been highly meaningful to the patient in some way, even though the companion did not actively participate in the interactions with team members.

### Conclusion and Implications

This qualitative study of the roles of companions in geriatric oncology patient-interdisciplinary team member interactions provides extension of studies of the roles of companions in physician-patient interactions. Companions appeared to play similar roles in interactions with interdisciplinary team members as they do in physician-patient interactions. Companions roles included memory aid, emotional support, transcriber, aid in decision making, companionship, elaboration, advocate for patient, and interpreter. As others have noted (e.g., Adelman et al., 1987), companions are likely to play multiple roles in a single interaction, and companion roles were found to shift over time within and across the interdisciplinary team interactions. Specific patterns of variability were identified: relatively passive companions who performed more active roles when the physician was present than with nonphysician team members; relatively active companions who performed more passive roles when the physician was present than with nonphysician team members; and relatively passive companions who performed more active roles only when particular topics were raised, regardless of the discipline of the team member. Two patterns of relative stability also were found in a smaller number of companions who consistently were either highly active or relatively passive. There are three primary implications of these findings on companion roles for geriatric interdisciplinary practice.

First, interdisciplinary geriatric oncology teams should consider taking steps to reinforce the importance of the roles of nonphysician team members to companions and patients. The analysis reported in this study demonstrates that a considerable proportion of companions confer greater prestige on physicians than on members of other disciplines and that such attitudes seem to relate to companions' levels of involvement in interactions between the patients and team members.

Informing patients and companions, either ahead of time in a written letter or during the orientation phase of the visit, of the team's position that all aspects of the assessment are vital could enhance

perceptions of the importance of nonphysician team members' functions among companions. Having such a letter or message bear the signature of one or more of a team's physicians also may help to increase the credibility of the nonphysician team members, albeit while also further reinforcing the physicians' prestige and authority.

Second, companions who are highly active in interactions provide important information and perspectives, but they also may marginalize patients' views. Given that the companions' roles shift over the course of the visit and are often integral to the interactions with team members, establishing a standard practice of asking companions to leave the room for some part of the comprehensive geriatric assessment may be advisable. Such a practice would give team members an opportunity to interact with the patient directly without companion intervention, thus giving patients and team members the opportunity to discuss some issues privately. Privacy could aid in the detection of abuse or neglect, as well as conditions that are harder to notice when the companion is available to provide information, explanations, and other forms of assistance for patients. Further, one-on-one interaction between patients and one or more team members could also help to avoid reinforcement by companions and team members of ageist stereotypes that inappropriately restrict older patients' autonomy (Hasselkus, 1994; for reflexive development of ageist stereotypes between patients and health care providers, see also Ryan, et al., 1995). That is, with the companion absent, intentional or accidental exclusion or marginalization of the geriatric patient from the conversation is not possible. In the particular clinical setting in this study, team members found it difficult to diplomatically remove problematic companions without a set protocol for doing so. Establishing a policy would potentially ease the process by providing an appropriate time in the visit, a set place for companions to go, and perhaps a task in which companions could engage (e.g., completing a questionnaire, reading a pamphlet).

Finally, examination of the roles of companions in the interdisciplinary team context of care further highlights the need for models of health care provider-patient communication that are triadic (or quadratic) rather than dyadic in structure (Adelman et al, 1987) and move beyond emphasis on the physician-patient dyad to embrace a multiplicity of health care disciplines (Haug, 1988). In the geriatric oncology team context, interaction with patients is lengthier and is designed to investigate even more aspects of the patients' life than in the typical physician-patient interaction. Therefore companions have more opportunities to perform a variety of roles, making the inclusion of their presence even more critical to conceptualizations of communication within this context.

## Endnotes

1. However, poor communication between older patients and health care providers may be due to mutual reinforcement of stereotypes of the aged, rather than simply ageism. Ryan, Meredith, and MacLean (1995) argue that provider-older patient communication processes are established and maintained reflexively. That is, providers' expectations of older patients invoke stereotypes which cause providers to modify their communication. Patients thus encounter constrained opportunities for communication as well as reinforcement for conforming to providers' expectations. This may lead to a loss of self esteem and lessened social interaction, which may encourage older patients to be more passive and to exhibit "old age cues," further reinforcing stereotypes and expectations.

2. Gender bias is common in physicians; for example, research has demonstrated gender bias in treatment of lung cancer, cardiovascular disease, and kidney failure (van Wijk, van Vliet, & Kolk, 1996); rates of prescription for activity restriction (Safran, Rogers, Tarlov, McHorney, & Ware, 1997); and psychosomatic diagnoses (Bernstein & Kane, 1981).

3. All of whom were in very good health overall and highly functional, with chronic, controlled rather than acute conditions and already had their diagnoses for some time.

4. Despite the best intentions of the team and the scheduling office, not all patients received the information packet that explains the interdisciplinary team approach and asks patients to fill out some preliminary paperwork before their visit. The registered nurse was often called upon to explain to the patient and companions that they would be undergoing a comprehensive assessment.

5. It is, of course, quite possible that my presence did have an impact on the interactions between team members, patients, and companions. However, given the research emphasis of the cancer center and the interdisciplinary nature of the clinic, my presence as a researcher was not unusual or disruptive. Patients were routinely approached about participating in various studies and trials, and they interacted with a wide range of team members from a variety of disciplines. In

addition, students from pharmacology, nursing, and medicine frequently accompanied team members in patient interactions.

Given the length of the initial visit, I entered and exited the rooms with team members several times, and there were opportunities for the patients and companions to ask me questions. They sometimes asked me about my research project and about my personal life. I walk with a pronounced limp due to reconstructive surgery for osteogenic sarcoma in my right leg, and was often asked about it. I answered any and all questions from patients and companions about my personal interest in the topic, but I avoided discussing what specifically I was studying except to say that I wanted to understand how patients and team members communicated with each other. While I did not announce my identity as a cancer survivor without being asked, I did reveal it when asked about my limp and leg brace, because I believe it would have been unethical to deceive patients and their companions about my status as a cancer survivor. When I did share this information, it appeared to make patients more comfortable; patients and companions often said that they were glad that I had at least some idea of what they were experiencing, and that it was comforting to talk with a survivor. See Ellingson (1998) for a more thorough discussion of the position of the cancer-survivor-as-researcher in the clinic setting.

6. Of course, it would be inappropriate for me to provide explanations or opinions. I always offered to get the registered nurse or nurse practitioner to answer their questions.

## References

Abramson, J. S., & Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. Social Work, 41, 270-281.

Adelman, R. D., Greene, M. G., & Charon, R. (1987). The physician-elderly patient-companion triad in the medical encounter: The development of a conceptual framework and research agenda. The Gerontologist, 27, 729-734.

Adelman, R. D., Greene, M. G., & Charon, R. (1991). Issues in physician-elderly patient interaction. Aging and Society, 2, 127-148.

Adelman, R. D., Greene, M. G., Charon, R., & Friedmann, E. (1990). Issues in the physician-geriatric patient relationship. In H. Giles, N. Coupland, & J. M. Wiemann (Eds.), Communication, health, and the elderly (pp. 126-134). London: Manchester University Press.

Allman, J. , Ragan, S. L., Newsome, C., Scoufos, L., & Nussbaum, J. (1999). Elderly women speak about interactions with health care providers. In H. E. Hamilton (Ed.), Language and communication in old age (pp. 319-349). New York: Garland Publishing.

Beisecker, A. E. (1988). Aging and the desire for information and input in medical decisions: Patients consumerism in medical encounters. The Gerontologist, 29, 330-335.

Beisecker, A. E. (1989). The influence of a companion on the doctor-elderly patient interaction. Health Communication, 1, 55-70.

Beisecker, A. E. (1996). Older persons' medical encounters and their outcomes. Research On Aging, 18, 9-31.

Beisecker, A. E., Brecheisen, M. A., Ashworth, J., & Hayes, J. (1996). Perceptions of the role of cancer patients' companions during medical appointments. Journal of Psychosocial Oncology, 14(4), 29-45.

Beisecker, A. E., & Moore, W. P. (1994). Oncologists' perceptions of the effects of cancer patients' companions on physician-patient interaction. Journal of Psychosocial Oncology, 12(1), 23-39.

Bernstein, B., & Kane, R. (1981). Physicians attitudes toward female patients. Medical Care, 19, 600.

Bertakis, K. D., Callahan, E. J., & Helms, L. J. (1993). The effect of patient health status on physician practice style. Family Medicine, 25, 530-535.

Borges, S. & Waitzkin, H. (1995). Women's narratives in primary medical care encounters. Women and Health, 23, 1, 29-56.

Breemhaar, B., Visser, A., & Kleijnen, J. (1990). Perceptions and behavior among elderly hospital patients: Description and explanation of age differences in satisfaction, knowledge, emotions, and behaviour. Social Science and Medicine, 31, 1377-1384.

Brody, H. (1992). The healer's power. New Haven: Yale University Press.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin, & Y. S. Lincoln (Eds.), Handbook of qualitative research, second edition, (pp. 509-535). Thousand Oaks, CA: Sage.

Clark, J. A., Potter, D. A., & McKinlay, J. B. (1990). Bringing structure back into clinical decision making. Social Science and Medicine, 31, 1377-1384.

Coe, R. M., & Prendergast, C. G. (1985). The formation of coalitions: Interaction strategies in triads. Sociology of Health and Illness, 7, 236-247.

Cooley, E. (1994). Training an interdisciplinary team in communication and decision-making skills. Small Group Research, 25, 5-25.

Ellingson, L. L. (1998). "Then you know how I feel": Empathy, identification, and reflexivity in fieldwork. Qualitative Inquiry, 4, 492-514.

Ellingson, L. L. (2001). Communicating across disciplines: A feminist ethnography of collaboration on a geriatric oncology team. Unpublished dissertation. University of South Florida.

Fisher, S. (1984). Doctor-patient communication: A social and micro-political performance. Sociology of Health and Illness, 6, 1-29.

Fisher, S. (1986). In the patient's best interest: Women and the politics of medical decisions. New Brunswick, NJ: Rutgers University Press.

Ford, C. V., & Sbordone, R. J. (1980). Attitudes of psychiatrists toward elderly patients. American Journal of Psychiatry, 137, 571-575.

Gabbard-Alley, A. S. (1995). Health communication and gender: A review and critique. Health Communication, 7, 35-54.

Glaser, B., & Strauss, B. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago: Aldine.

Glasser, M., Prohaska, T., & Roska, J. (1992). The role of family in medical care-seeking decisions of older adults. Family and Community Medicine, 15, 59-70.

Glasser, M., Rubin, S., & Dickover, M. (1989). Caregiver views of help from the physician. The American Journal of Alzheimer's Care and Related Disorders and Research, 4, 11.

Glasser, M., Rubin, S., & Dickover, M. (1990). The caregiver role: Review of family caregiver-physician relations and dementing disorders. In S. M. Stahl (Ed.), The legacy of longevity (pp. 321-337). Newbury Park, CA: Sage.

Greene, M. G., Majerovitz, D., Adelman, R. D., & Rizzo, C. (1994). The effects of the presence of a third person on the physician-older patient medical interview. Journal of the American Geriatrics Society, 42, 413-419.

Haley, W. E., Clair, J. M., & Saulsberry, K. (1992). Caregiver satisfaction with medical care of their demented relatives. The Gerontologist, 32, 219-226.

Hall, J. A., Epstein, A. M., DeCiantis, M. L., & McNeil, B. J. (1993). Physicians' like for their patients: More evidence for the role of affect in medical care. Healthy Psychology, 12, 140-146.

Hasselkus, B. R. (1992). Physician and family caregiver in the medical setting: Negotiation of care? Journal of Aging Studies, 6, 67-80.

Hasselkus, B. R. (1994). Three-track care: Older patient, family member, and physician in the medical visit. Journal of Aging Studies, 8, 281-307.

Haug, M. R. (1988). Professional client relationships and the older patient. In S. K. Steinmetz (Ed.), Family and support systems across the life span (pp. 225-242). New York: Plenum Press.

Haug, M. R. (1996). Elements in physician/patient interactions in late life. Research on Aging, 18, 32-51.

Haug, M. R., & Ory, M. (1987). Issues in elderly patient-provider interaction. Research on Aging, 9, 3-44.

Jackson, P. B., & George, L. K. (1998). Racial differences in satisfaction with physicians: A study of older adults. Research on Aging, 20, 298-316.

Labrecque, M. S., Blanchard, C. G., Ruckdeschel, J. C., Blanchard, E. B. (1991). The impact of family presence on the physician-cancer patient interaction. Social Science and Medicine, 33, 1253-1261.

Lefer, L. (1981). The lame, the halt, the blind, and the intact elderly person in the doctors' office. Journal of Oral Medicine, 36, 90-96.

Lichtenstein, R., Alexander, J. A., Jinnett, K., & Ullman, E. (1997). Embedded intergroup relations in interdisciplinary teams: Effects on perceptions of level of team integration. Journal of Applied Behavioral Science, 33, 413-434.

Lindlof, T. R. (1995). Qualitative communication research methods. Thousand Oaks, CA: Sage.

McCormick, W. C., Inui, T. S., & Roter, D. L. (1996). Interventions in physician-elderly patient interactions. Research on Aging, 18, 103-136.

Miller, D. K., Morley, J. E., Rubenstein, L. Z., Pietruszka, F. M., & Strome, L. S. (1990). Formal geriatric assessment instruments and the care of older general medical outpatients. Journal of the American Geriatrics Society, 38, 645-651.

Owen, W. F. (1984). Interpretive themes in relational communication. Quarterly Journal of Speech, 70, 274-287.

Owens, D. J., & Batchelor, C. (1996). Patient satisfaction and the elderly. Social Science and Medicine, 42, 1483-1491.

Pendleton, D. A., & Bochner, S. (1980). The communication of medical information in general practice consultations as a function of patients' social class. Social Science and Medicine, 14A, 669-673.

Prohaska, T. R., & Glasser, M. (1996). Patients' views of family involvement in medical care decisions and encounters. Research on Aging, 18, 52-69.

Rosow, I. (1981). Coalitions in geriatric medicine. In M. R. Haug (Ed.), Elderly patients and their doctors (pp. 137-146). New York: Springer.

Rubenstein, L. Z., Josephson, K. R., Wieland, G. D., English, P. A., Sere, J. A., & Kane, R. L. (1984). Effectiveness of a geriatric evaluation unit: A randomized clinical trial. New England Journal of Medicine, 311, 1664-1670.

Rubenstein, L. Z., Stuck, A. E., Siu, A L., & Wieland, D. (1991). Impacts of geriatric evaluation and management programs on defined outcomes: Overview of the evidence. Journal of the American Geriatrics Society, 39(supplement), 9S-16S.

Ryan, E. B., Meredith, S. D., & MacLean, M. J. (1995). Changing the way we talk with elders: Promoting health using the communication enhancement model. International Journal of Aging and Human Development, 41, 89-107.

Safran, D. G., Rogers, W. H., Tarlov, A. R., McHorney, C. A., & Ware, Jr., J. E. (1997). Gender difference in medical treatment: The case of physician-prescribed activity restrictions. Social Science and Medicine, 45, 711-722.

Satin, D. G. (1994). The interdisciplinary, integrated approach to professional practice with the aged. In D. G. Satin (Ed.), The clinical care of the aged person.: An interdisciplinary perspective (pp. 391-403). New York: Oxford University Press.

Siegel, B. S. (1994). Developing interdisciplinary teams. In D. G. Satin (Ed.), The clinical care of the aged person: An interdisciplinary perspective (pp. 404-425). New York: Oxford University Press.

Stahelski, A. J., & Tsukuda, R. A. (1990). Predictors of cooperation in health care teams. Small Group Research, 21, 220-233.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research : Techniques and procedures for developing grounded theory, 2nd ed. Thousand Oaks, CA: Sage.

Thompson, T. L. (1994). Interpersonal communication and health care. In M. L. Knapp & G. R. Miller (Eds.), Handbook of interpersonal communication (second edition) (pp. 696-725). Thousand Oaks, CA: Sage.

van Wijk, C. M. T. G., van Vliet, K. P., & Kolk, A. M. (1996). Gender perspectives and quality of care: Towards appropriate and adequate health care for women. Social Science and Medicine, 43, 707-720.

Wieder, A. J. (1994). When medications change, tell the caregiver too. Geriatrics, 49(8), 48-50.

Wieland, D., Kramer, B. J., Waite, M. S., & Rubenstein, L. Z. (1996). The interdisciplinary team in geriatric care. American Behavioral Scientist, 39, 655-664.