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Examining the Context and Helpfulness of Family Companion Contributions to Older Adults' Primary Care Visits

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Abstract

Objective—Older adults commonly involve family (broadly defined) in their care. We examined communication behaviors of family companions during older adults' primary care visits, including whether these behaviors vary with respect to how older adults manage their health, preferences for involving family in medical decision-making, and ratings of companion helpfulness.

Methods—Analysis of audio-taped primary care visits of older patients who were accompanied by a family companion (n=30 dyads) and linked patient surveys.

Results—Family companions predominantly facilitated doctor and patient information exchange. More than half of companion communication behaviors were directed at improving doctor understanding of the patient. Companions were more verbally active during visits of patients who delegated the management of their health to others than visits of patients who co-managed or self-managed their health. Companions were rated as more helpful by patients who preferred active involvement of family in medical decision-making.

Conclusion—Family companion participation and helpfulness in primary care communication varies by patients' preferences for involving family in medical decision-making and approach to managing their health.

Practice Implications—Research to examine the effects of clarifying patient and family companion expectations for primary care visits could inform strategies to improve the patient-centeredness of medical communication.

Keywords

Family caregiver; primary health care; physician office; patient-provider communication

1. INTRODUCTION

Person- and family-centered care is one of six defined priorities of a high performing health system, [1, 2] and is particularly relevant in the care of older persons due to their high likelihood of encountering “preference-sensitive” decisions in which optimal care is guided by patient priorities and values.[3] Older adults commonly rely on or choose to involve family (broadly defined; including both relatives and friends) in medical decision-making and in managing their health.[4, 5] However, supporting family involvement in care delivery is not straightforward. Older adults vary in their preferences for actively participating in care [5, 6] as well as their desire for involving family in care processes and medical decision-making. [5, 7–9] Family members vary in their knowledge of older adults' health conditions and priorities, [10–12] as well as their capacity or motivation to participate in care processes and decision-making. [7, 9, 12, 13]

A small but growing body of literature has examined the behaviors of family “companions” who accompany older patients to medical visits.[8, 14] Seminal work in this area by Clayman and colleagues involved the development of a typology to categorize companion verbal communication behaviors as autonomy enhancing or autonomy detracting. Companions were found to most often engage in “autonomy enhancing” behaviors by clarifying health information, facilitating patient and doctor understanding, and prompting

patients to participate in visit discussion.[15, 16] Patients were more than four times as likely to be active in medical decision-making when their companions behaved in this way. Behaviors such as interrupting, speaking for, or criticizing the patient, categorized as “autonomy detracting” were performed less often and were not associated with patient participation in medical decision-making. Although this work suggests benefit from family companion involvement in older adults’ medical visit communication, broader interpretation is limited by reliance on a single sample and the absence of information regarding how patients managed their health or their preferences for involving family in medical decision-making.

A better understanding of family companions’ involvement in older adults’ primary care visits is relevant to efforts to engage families in shared decision-making [4, 8, 17] and in care. [18, 19] A recent nationally representative study found that older adults’ decision-making preferences varied widely with respect to whether they managed their health independently or with the involvement of family.[5] Other studies find that patients commonly engage in treatment planning with family but that the nature and degree of family involvement is highly variable[7, 9, 12] with low congruence in patient and family expectations regarding the role of family and patient preferences for communication assistance from family. [10–12] Finally, a study of older Japanese primary care patients found that patients rated companions as especially helpful when the companion actively participated in medical visit communication as expected by the patient.[20] If the patient anticipated only a limited companion role, the companion was not viewed as very helpful regardless of the role they assumed.

This study draws on linked audiotaped primary care visits and patient surveys from a trial of a patient-companion communication intervention to extend this literature in several ways. First, we replicate Clayman’s categorization of family companion verbal communication behaviors in a new sample of older adults’ primary care visits. Second, we examine whether and how older adults’ approach to managing their health and decision-making preferences correspond to family communication behaviors during primary care visits. Third, we evaluate patient ratings of companion helpfulness, focusing specifically on whether such ratings vary with respect to the communication behaviors the companion performed and patient preferences for decision-making. Following the work of Ishikawa, [20] we hypothesized that patients would report companions to be most helpful when companion contribution to visit communication was consistent with patients’ preferences. Finally, we examine whether a patient-companion pre-visit agenda-setting intervention that was previously found to improve the patient-centeredness of visit communication, [21] affected companion communication behaviors.

2. METHODS

We examined a convenience sample of audio-taped primary care visits with linked information of patient responses to post-visit surveys. Study participants were patients, family companions, and geriatricians who participated in a pilot study of a patient-companion communication intervention that was conducted in an academic geriatrics clinic between April and August 2012. Detailed information regarding study recruitment and

response rates have been previously reported.[21] Inclusion criteria for patients included being age 65 or older, English speaking, hearing well enough to communicate by telephone, seeing well enough to read large print, and being typically accompanied to doctor visits by an unpaid family member or friend. Older adults with significant cognitive deficits, defined as more than two incorrect answers on a 6-item cognitive screen[22], were excluded from study participation. Comparable eligibility criteria for sensory and cognitive impairment applied to companions, who also completed screening calls.

Eligible patient–companion dyads who expressed an interest in participating in the study met a member of the research team 30 minutes before a regularly scheduled appointment in the physician’s office waiting room. After providing informed consent, each dyad was randomized to receive either the intervention or control protocol. The control protocol comprised care as usual, with patients proceeding to the scheduled visit following routine clinic processes. The intervention protocol involved patients and companions completing a brief self-administered agenda-setting checklist in the waiting room prior to the scheduled visit. The agenda-setting checklist involved two activities: (1) to elicit and align patient and companion perspectives regarding patients’ health concerns to discuss with the doctor, and (2) to stimulate discussion between patients and companions about the role of the companion in the visit. The premise for the agenda-setting checklist is that companions are typically motivated to support patients during medical visits but often lack knowledge of the patients’ health concerns and preferences for communication assistance.

All medical encounters were audio-recorded but otherwise transpired as usual. Both patients and companions completed surveys immediately after the visit as well as by telephone 2 weeks after the visit to answer questions about the medical visit and their sociodemographic characteristics, health status, and relationship to one another. The final study sample comprised 32 distinct older adult-companion dyads. Due to the complexity of four-way conversation, we excluded a joint visit of two patient participants who were accompanied by an adult child, leaving a final sample of 30 older adult-companion dyads.

2.1. Study Measures

Participant socio-demographic characteristics—Patients were asked to report socio-demographic characteristics including age, gender, educational attainment, and relationship, and health status. Patients were additionally asked how they manage their health and questions about their preferences for participating in medical-decision-making.

Patient approach to managing health care activities—Patients were read the statement: “People today are asked by their doctors and other health care providers to do many things to stay healthy or treat health problems—for example, manage medicines, get tests and lab work done, watch weight and blood pressure, or have yearly exams.” They were then asked “How do you usually handle these things?” and to select from structured response categories. Patients’ approach to managing their health was categorized as “self-manage”, “co-manage”, or “delegate” following previously described cut-points.[5]

Patient preferences for involving family in medical decision-making—Given recent conceptual work indicating the importance of family and close friends as elements of

informed decision-making, [4, 23] we asked patients to report their preferences for participating in medical decision-making with family/close friends. Patients were read the statement: “People today are faced with many decisions about their health care—for example whether to start or change a medicine. We want to know how you prefer to have family or close friends help with decisions.” Response categories included: “making decisions independently, with or without advice”, “share decisions” and “leave decisions up to them.”

Companion helpfulness—Immediately after the visit, patients were asked to report how the companion’s involvement affected communication during their medical visit. Questions were asked about five positive and two negative aspects of the companion’s involvement in the medical visit along a 5-point Likert scale response ranging from “strongly agree” to “strongly disagree.” Positive items included “my doctor understood my concerns more fully”, “I better understood my doctor’s advice and explanations”, “I felt more comfortable talking with my doctor”, “I was better able to explain my problems and concerns”, and “I am more confident about decisions that were made.” Negative items included “I was not able to talk to the doctor as openly”, and “My companion told the doctor information I did not want to share.” Responses to negative items were highly skewed and rarely endorsed, and were therefore dropped in this analysis.

Following the approach used by Ishikawa, [20] we constructed a summary scale from the items regarding the ways that companions positively affected visit communication. Each item contributed up to two points if the patient “strongly agreed” and 1 point if the patient “agreed” with the question; 0 points awarded if the patient reported the companion made “no difference” or if they “disagreed” or “strongly disagreed.” The summary scale ranged in value from 0 to 10 and was found to have adequate internal constancy (Cronbach’s $\alpha=0.88$). Because the score is limited to patients’ ratings of how companions’ involvement was beneficial, it reflects variation in patient perceptions of companion helpfulness. Low scores are indicative that the companion was judged to be less (relative to more) helpful rather than being unhelpful.

Interaction analysis and companion behaviors—Recordings of medical visit dialogue were coded using the Roter Interaction Analysis System (RIAS), a validated system for empirically describing medical visit communication.[24] The unit of analysis is a complete thought assigned to 38 mutually exclusive and exhaustive categories that are mostly parallel for each speaker. In this analysis we report summary measures of patient and companion verbal activity, which reflects the proportion of visit statements contributed by the patient and companion, respectively. We additionally examined duration of medical visits, in minutes.

Audiotapes of medical visits were transcribed and companion involvement in communication was coded from transcripts using Nvivo 10 software following the previously defined categories described by Clayman. Transcript examples of these behaviors are presented in Table 1.[15, 16] We constructed a summary measure to differentiate “higher” from “lower” companion engagement using a cut-point of the mean number of combined (autonomy enhancing and autonomy detracting) behaviors for the study sample.

2.2. Data Analysis

Analyses were performed using SAS version 9.4 (SAS Institute, Inc., Cary, NC), with each patient-companion dyad and their medical visit as the unit of analysis. We first analyzed the observed frequency of companions' autonomy-related behaviors from transcripts of audio-recorded medical dialogue. We computed the average frequency of each companion behavior per visit and the distribution of behaviors across all visits. We next examined patient reports of how they manage their health and their preferences for involving family in medical decision-making. The frequency of companion communication behaviors was then examined with respect to how patients' reported managing their health and decision-making preferences. We used SAS PROC GLM for unbalanced analysis of variance to examine whether older adults' approach to managing their health and preferences for involving family in medical decisions was related to companions' actual behaviors during visit communication. The small sample size precluded our ability to adjust for the many patient factors that may relate to companions' behaviors during medical visits. As treatment group was a key independent variable of interest it was included as a dichotomous measure in analysis of variance regression models. Finally, we examined how patient preferences for involving family in medical decision-making related to their ratings of companions' helpfulness in visit communication using the same analysis of variance analytic approach that has been described above. These results were empirically examined and displayed graphically.

3. RESULTS

Patient participants (n=30) were on average 81.2 years of age, 60.0% were female, and 46.7% completed high school or some college (Table 2). Patients rated their health as excellent/very good (30.0%), good (26.7%), or fair/poor (43.3%). Companions were adult children (50.0%), spouses (33.3%), and other relatives or friends (16.7%). Aside from companions in the intervention group being less likely to be female, no other statistically significant treatment group differences were observed in patient or companion characteristics. Most (87.5%) patients reported that their companion was the person who helped them "the most" with a range of personal care (dressing, bathing), transportation, administrative (handling bills and paperwork), and health care (medications, scheduling and attending appointments, coordinating care and services) activities (data not shown).

Although companions communicated in varied ways, their contributions to communication were primarily directed at improving the exchange of information and an understanding between doctors and patients. Autonomy enhancing behaviors such as repeating the doctor's explanations, introducing medical topics, and clarifying medical information, were observed an average of 35 times per visit, representing 81% of all companion behavior (Table 3, top). The dominant behavior assumed by companions was to clarify or expand upon the patients' medical information and history to facilitate doctor understanding, which comprised 55% of all companion behaviors and occurred an average of 25 times per visit. Companions also facilitated patient understanding, mostly by asking the doctor questions, (averaging 5.5 times per visit and 13% of companion behaviors) and they facilitated patient involvement by asking the patient questions, (averaging 4.4 times per visit and 10% of companion

behaviors). Autonomy detracting behaviors were observed an average of 8 times in each primary care visit, representing 19% of all companion behaviors (Table 3, bottom). The most common autonomy detracting behavior was correcting or blaming the patient (e.g., “She just wants to sit there and do this or put her feet up; she is terrible about it” or “What I observe with my own eyes” in highlighting a difference in information than stated by the patient) which were observed an average of 2 times per visit, representing 5% of all behaviors.

Most patients self-managed (n=15; 50.0%) or co-managed their health (n=12; 40.0%); few delegated management of their health to family or friends (n=3; 10.0%; Table 4). However, patients who delegated the management of their health to others were significantly less verbally active than those who co-managed or self-managed their health (16.8% vs. 42.6% and 40.3%; $p<0.001$) whereas their companions were significantly more verbally active (45.2% of statements vs. 14.5% and 13.8%, respectively; $p<0.001$). Companions of patients who delegated management of their health to others engaged in more behaviors directed at promoting patient autonomy than those of patients who co-managed or self-managed their health (73.4 behaviors/visit versus 37.4 and 25.2, respectively; $p<0.05$) most notably, to facilitate doctor understanding (58.3 behaviors/visit versus 26.6 and 17.0; $p<0.01$). These companions also assumed more autonomy detracting behaviors than companions of those who co-managed or self-managed their health (26.0 versus 6.8 and 5.2; $p<0.01$). This is most notable with respect to behaviors characterized as controlling of the patient (22.7 behaviors/visit versus 5.7 and 4.6; $p<0.01$). Although companions who completed the pre-visit agenda-setting intervention contributed more autonomy enhancing behaviors than their control group counterparts (47.2 behaviors/visit versus 43.5), most notably with respect to facilitating doctor understanding (37.1 behaviors/visit versus 30.9), treatment group differences were not statistically significant.

Patients preferred to make medical decisions independently (n=13; 43.3%) or to share decisions with family and close friends (n=14; 46.7%); few preferred to leave decisions to family and close friends (n=3; 10.0%). Medical visits of patients who preferred to leave medical decisions to family/close friends were shorter (20.5 minutes) than visits of patients who preferred to share decisions with family (38.8 minutes) or those who preferred to make decisions independently (31.6 minutes; $p<0.05$). Patients who preferred to leave medical decisions to family/close friends were less verbally active than their counterparts with shared or independent decision-making preferences although this difference was not statistically significant (26.2% of visit statements versus 41.4% and 39.2%, respectively). No statistically significant differences in companion communication behaviors were observed with respect to patient decision-making preferences or treatment group.

Finally, we examined patient ratings of companion helpfulness. As depicted in Figure 1, patients who preferred to leave medical decisions to family or close friends rated companions as significantly more helpful than patients with shared or independent decision-making preferences (mean score of 6.7, 4.6, and 2.5, respectively; $p=0.05$). For each of the three groups, companions who participated more actively in communication were rated as more helpful, although these differences were not statistically significant.

4. DISCUSSION AND CONCLUSION

4.1. Discussion

This small exploratory study extends a nascent line of investigation describing the contributions of family companions in older adults' medical visits. Companions were more verbally active and engaged in more communication behaviors directed at facilitating provider understanding when they accompanied patients who relied on others to manage their health. Visits were longer among patients who preferred to share medical decisions with family, however companion communication behaviors did not vary with respect to patients' decision-making preferences or having completed a pre-visit agenda-setting communication intervention. As hypothesized, patients who expressed a preference for sharing or leaving decisions to family/close friends reported their companions to be more helpful during visit communication than patients who preferred to make decisions independently.

Family companions' contributions to medical communication were highly consistent with those reported by Clayman [15]. More than half of family companion communications during visits were directed toward facilitating doctor understanding by clarifying or expanding on information that pertained to the patients' health or medical history. Companion behaviors were also commonly directed at improving patient understanding and prompting patients to participate in visit communication. Although companions performed autonomy detracting behaviors such as interrupting, speaking for, or criticizing the patient, these communication behaviors were less common than autonomy enhancing behaviors and they never occurred in isolation of autonomy enhancing behaviors.

Our findings are consistent with prior conceptual [1] and empirical work [8, 14] suggesting that family companions typically facilitate sharing of information and more informed medical decision-making and may benefit patients' experience and self-management. [14, 25] Although family involvement in medical decision-making is commonly desired and even expected by older adults [4, 5, 26], ambiguity in family companions' understanding of patient perspectives and communication preferences [9, 12, 17, 20] may challenge the ability of well-intended and motivated family members to support patients as they desire. To this end, it is notable that although family companions' communication behaviors were highly associated with how patients managed their health, communication behaviors did not vary with respect to patients' preferences for involving family in medical decision-making.

Previous efforts to improve medical decision-making have predominantly focused on patient-directed decision-aids and interventions that increase patient participation in care [19, 27, 28] or strategies to improve providers' abilities to engage in "preference-matched" communication that is tailored to individual patients. [6] Less effort has been directed at understanding and improving the capacity of family companions to productively engage in communication during face-to-face medical visits. [17, 29] We are unaware of studies other than our own [21] that have sought to strengthen family involvement by clarifying patients' desired communication assistance. Strategies to elicit discussion between patients and families regarding patients' treatment goals, priorities, and preferences merits consideration in light of evidence that patient-family agreement is generally low. [10–12, 30] Moreover, as

poor agreement between patients and families may be inversely associated with effective illness management, care planning, and quality of life [6, 10, 11, 31] strategies leading to a stronger patient-family partnership during medical communication could be of interest to a range of health system stakeholders. Although the pilot trial from which the data for this study originated improved the patient centeredness of medical visit communication, [21] we did not find evidence to suggest that the intervention exerted a significant effect on companions' communication behaviors.

Results from this study are qualified by several limitations. In particular, this is an exploratory study that relies on convenience sample of older patients and companions from a single academic geriatric clinic. Our study focuses on interpersonal processes involving a family companion for the selected sample of older patients who are typically accompanied to medical visits. Due to the small sample we were not able to develop multivariate regression models or stratify the sample to examine variability in companion communication behaviors by patient or family companion characteristics. Older adults with significant cognitive impairment were excluded from our study, and we are not able to comment on how findings relate to older adults with dementia, for whom family caregivers are known to play a particularly influential role in the communication of information with health professionals [32, 33] Our assessment of patient preferences for involving family and close friends in medical decision-making was constrained to a single question and we are unable to definitively establish that patients' decision-making preferences corresponded to the family companion who accompanied the patient to their visit. Finally, the single question that was asked about patients decision-making preferences for involving family limits our ability to distinguish preferences across varied decisions for specific health issues.[9, 34]

4.2 Conclusion

Study findings support growing evidence indicating that family companions typically exert a beneficial role on medical visit communication by facilitating information exchange and informed medical decision-making between patients and doctors. The importance of respecting individuals' information and communication preferences when interacting with patients is well established.[19, 28, 35] That family companions were rated as more helpful when patients expressed a preference for active family involvement in medical decision-making substantiates the importance of "preference-matched" care that is tailored to individual priorities and values.[6]

4.3 Practice Implications

Older adults who are more vulnerable and who have complex health needs commonly choose to involve family and unpaid caregivers when communicating with health professionals and managing their care. [5, 14, 36] However, aside from our prior work, [21] little attention has been directed at developing interventional strategies to purposefully engage family companions in primary care visits in a manner that respects patients' preferences.[17] In our prior study, [21] patients and providers were significantly more likely to report that intervention companions contributed to effective exchange of information. Intervention visits were found to involve communication that was significantly more patient-centered than control visits. It is therefore notable that this analysis does not

indicate that the patient-companion agenda setting intervention affected family companion behaviors during primary care visits. Future interventional studies should build on our preliminary work by further refining and testing the patient-companion agenda-setting strategy in larger samples of diverse older patient-companion dyads and primary practice settings with the goal of understanding the mechanism by which the intervention may operate.

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Highlights

- Most family companion communication behaviors were directed at improving doctor understanding.
- Companions were more active in visits of patients who relied on others to manage their health.
- Companions were rated as more helpful by patients who prefer family involvement in decision-making.
- Family participation and helpfulness in medical visits vary by patient factors.

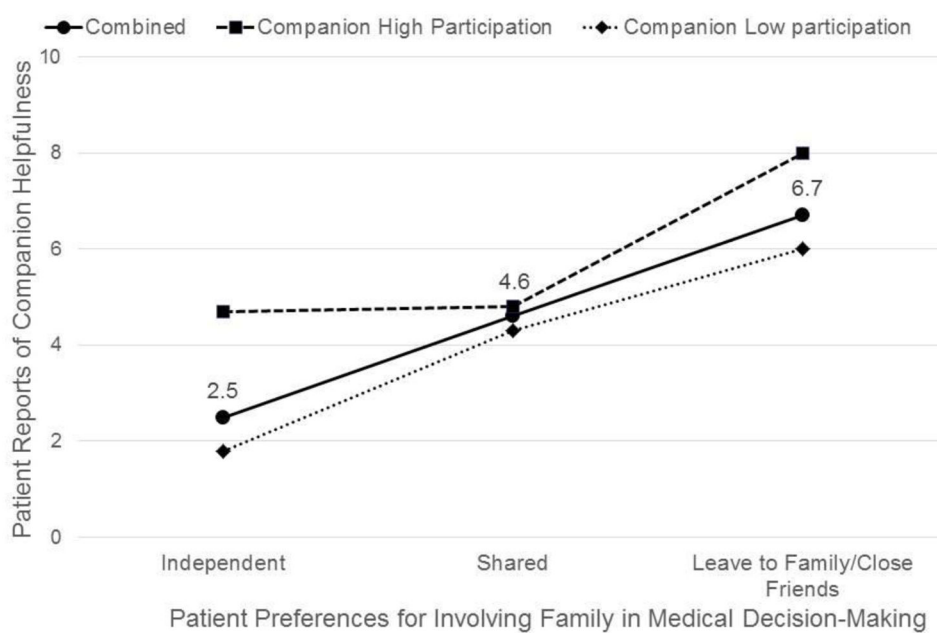


Figure 1.
Patient Reports of Companion Helpfulness in Medical Visits

Table 1

Autonomy-related companion behaviors and coding examples

| Companion behaviors | Coding examples |
|--|---|
| Autonomy-enhancing behaviors | |
| <i>Facilitating patient understanding</i> | |
| Repeat doctor's explanations | C: In other words, what he's saying is you go every hour instead of just waiting until you have to go; that's what he's saying. |
| Ask doctor questions | C: Should he stop taking the baby aspirin? |
| <i>Facilitating patient involvement</i> | |
| Prompt patient to discuss topics | C: Are you going to talk about your hearing? |
| Ask patient questions (open-ended) | C: What is the problem when you say you have a vision problem? |
| Ask patient questions (closed-ended) | C: Does that make you dizzy? |
| <i>Facilitating doctor understanding</i> | |
| Introduce medical topics | C: So let's talk about the nausea to be sure. |
| Clarify or expand medical information and history | C: She had pneumonia and the heart trouble. |
| Autonomy-detracting behaviors | |
| <i>Controlling toward the patient</i> | |
| Interrupt patient | P: I have them but... C: And I got the Centrum but she didn't like them; they're too big. |
| Discuss third party's health | C: My daughter has a lot of sleeping problems too. |
| Correct or blame patient | C: You poisoned yourself. |
| Companion as expert | C: Maybe it's a side effect of the medicine; maybe we need to change the dosage around a little bit. |
| Answer for the patient | D: The pain has been acting up a little more than usual? C: Yeah, yes. |
| <i>Alliance building</i> | |
| Persuade patient to do something doctor wants | C: When you're lying in bed before you get up, you need to do those exercises he was telling you about when you're lying there. |
| Gain physician agreement for something companion wants | C: So maybe you (the doctor) could tell him (the patient) how important that is. |

Note: P= patient; C=Companion; D= Doctor.

Table 2**Enrolled Study Sample by Group Assignment**

| Patient Characteristics | Group Assignment | |
|--|-------------------------------|--------------------------------|
| | Checklist n=16 (53.3%) | Usual Care n=14 (46.7%) |
| Total Sample (n=30) | 81.2 (65–99) | 82.4 (69–96) |
| Age, mean (range) | 80.2 (65–99) | 9 (64.3%) |
| Female; n (%) | 18 (60.0%) | |
| Educational attainment; n (%) | | |
| High school | 16 (53.3%) | 8 (57.1%) |
| College or beyond | 14 (46.7%) | 6 (42.9%) |
| Self-rated health; n (%) | | |
| Excellent/Very Good | 9 (30.0%) | 3 (21.4%) |
| Good | 8 (26.7%) | 3 (21.4%) |
| Fair/Poor | 12 (43.3%) | 8 (57.2%) |
| Years under physician care; mean (range) | 4.0 (1–15) | 3.9 (1–15) |
| Companion Characteristics | | |
| Age, mean (range) | 62.5 (35–81) | 64.9 (48–81) |
| Female; n (%) | 22 (73.3%) | 13 (92.9%) * |
| Relationship to Patient; n (%) | | |
| Spouse | 10 (33.3%) | 6 (42.9%) |
| Adult Child | 15 (50.0%) | 6 (42.9%) |
| Other (friend, partner, other relative) | 5 (16.7%) | 2 (14.3%) |
| Educational attainment; n (%) | | |
| High school | 6 (20.0%) | 2 (14.3%) |
| College or beyond | 24 (80.0%) | 12 (85.7%) |

*
p < 0.05

Table 3

Family companion communication behaviors during geriatric medical visits

| Types of companion communication behaviors | Distribution of companion behaviors (%) | Average number of behaviors per visit (#) |
|---|---|---|
| Autonomy-enhancing behaviors | 81.5% | 35.1 |
| <i>Facilitating doctor understanding</i> | | |
| Clarify/expand medical information, history | 58.6% | 25.2 |
| Introduce medical topics | 54.8% | 23.6 |
| <i>Facilitating patient understanding</i> | 3.8% | 1.6 |
| Ask doctor questions | 12.9% | 5.5 |
| Repeat doctor's explanations | 11.5% | 4.9 |
| <i>Facilitating patient involvement</i> | 1.4% | 0.6 |
| Ask patient questions (closed-ended) | 10.1% | 4.4 |
| Prompt patient to discuss topics | 6.7% | 2.9 |
| Ask patient questions (open-ended) | 1.9% | 0.8 |
| Autonomy-detracting behaviors | 18.5% | 8.0 |
| <i>Controlling toward the patient</i> | | |
| Answer for the patient | 16.0% | 6.9 |
| Interrupt patient | 3.9% | 1.7 |
| Discuss third party's health | 2.8% | 1.2 |
| Correct or blame patient | 3.1% | 1.3 |
| Companion as expert | 5.0% | 2.2 |
| <i>Alliance building</i> | 1.2% | 0.5 |
| Persuade patient to do something doctor wants | 2.5% | 1.1 |
| Gain physician agreement for companion wants | 1.5% | 0.7 |
| | 0.9% | 0.4 |

Companion behaviors, stratified by patients' approach to managing their health and preferences for companion involvement in medical decision-making

Table 4

| | Approach to Managing Health | | | | Treatment Group | |
|--|-----------------------------|-----------------------|----------------|---------------------|-----------------------|----------------|
| | Self-Manage (n=15) | Co-Manage (n=12) | Delegate (n=3) | Intervention (n=16) | Control (n=14) | |
| Visit Duration (minutes) | 31.3 | 37.7 | 31.3 | 35.2 | 31.6 | |
| Patient Verbal Activity | 40.3% | 42.6% | 16.8% *** | 32.9% | 33.6% | |
| Companion Verbal Activity | 13.8% | 14.5% | 45.2% *** | 25.2% | 23.7% | |
| Companion Communication Behaviors | | | | | | |
| Autonomy-enhancing behaviors | 25.2 | 37.4 | 73.4 * | 47.2 | 43.5 | |
| Facilitate doctor understanding | 17.0 | 26.6 | 58.3 ** | 37.1 | 30.9 | |
| Facilitate patient understanding | 4.6 | 5.3 | 11.2 | 6.5 | 7.6 | |
| Facilitate patient involvement | 4.3 | 5.6 | 4.3 | 3.7 | 5.2 | |
| Autonomy-detracting behaviors | 5.2 | 6.8 | 26.0 ** | 13.6 | 11.7 | |
| Controlling toward the patient | 4.6 | 5.7 | 22.7 ** | 11.9 | 10.1 | |
| Alliance building | 0.6 | 1.1 | 3.3 | 1.7 | 1.6 | |
| Decision-Making Preferences | | | | | | |
| | Independent (n=13) | | | Intervention (n=16) | | |
| | Share (n=14) | Leave to Others (n=3) | Control (n=14) | Share (n=14) | Leave to Others (n=3) | Control (n=14) |
| Visit Duration | 31.6 | 38.8 | 20.5 * | 31.9 | 28.7 | |
| Patient Verbal Activity | 39.2% | 41.4% | 26.2% | 34.9% | 36.3% | |
| Companion Verbal Activity | 16.1% | 15.9% | 27.1% | 21.2% | 18.3% | |
| Companion Communication Behaviors | | | | | | |
| Autonomy-enhancing behaviors | 31.5 | 37.0 | 39.2 | 39.3 | 32.6 | |
| Facilitate doctor understanding | 24.3 | 26.1 | 22.0 | 29.1 | 19.1 | |
| Facilitate patient understanding | 3.2 | 6.7 | 11.0 | 5.9 | 8.1 | |
| Facilitate patient involvement | 4.0 | 4.4 | 6.5 | 4.3 | 5.6 | |
| Autonomy-detracting behaviors | 9.9 | 7.1 | 1.9 | 8.7 | 3.9 | |
| Controlling toward the patient | 8.5 | 6.5 | 0.6 | 7.3 | 3.1 | |
| Alliance building | 1.4 | 0.6 | 1.2 | 1.4 | 0.8 | |

* p < 0.05;

100>0=d

;100>0=d
**

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