

Research Article

Implications of Companion Presence with or without the Patient in the Family Medicine Consultation

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Abstract

Objective: To evaluate the clinical implications between the presence of a companion with or without the patient in the office.

Design: Analytical observational study.

Location: A family medical consultation in Toledo, Spain.

Participants: Data from patients and their companions were collected, including whether the patient was present or not.

Main Measurements: For each patient and companion, the following variables were collected, among others: age, gender, chronic illness, chief complaint, drugs, social class, request for additional tests, kinship, social status and availability of companion. Comparisons were made using chi-square test, with Yates correction or Fisher's exact probability, Student's t-test and the Mann-Whitney test. Finally, an analysis using logistic regression was performed.

Results: Of the 106 patients included, 63% patient were with a companion, and 37% were companions without the patient being present in the office: The presence of the patient with the companion compared to visits without the patient was significantly associated with lower sick leave [6% vs. 23%; $p = 0.022$], were more often the wife or husband [51% vs. 27%; $p = 0.05$], there were fewer chronic diseases of the musculoskeletal group [21% vs. 44%, $p = 0.024$], and taking less drugs from this therapeutic group [10% vs. 31%; $p = 0.017$]. In the logistical regression analysis with the variables that showed statistical significance in the bivariate analysis, and using as the dependent variable "the patient is present in consulting room", significant differences were found in relatives (husband / wife), who has shown a O.R. of 2,701 (i.e., if the companion is the spouse of the patient, the patient's odds of presence increases 2,701 times).

Conclusions: 1) There is a high frequency of companions attending the office without patients, which has ethical implications, and can cause false positives and negatives that can have serious consequences; 2) Dismissing inconsistent relations, there is no difference between patients or companions either if the patient is present or not in the office; and 3) The likelihood that the patient is present in the consulting room is significantly only when the companion is the husband/wife of the patient.

Keywords: Companion; family; Physician-patient communications; Caregivers; Family practice; Office visits; Physician-patient relations; Professional-family relations

Introduction

The specialty of family medicine emphasizes the importance of assessing the patient's health, illness and disease within the context of family and community. Providing family-oriented primary care is one of the distinguishing features of this specialty [1,2].

Another important feature of family medicine which is taken into account in the individual care, is the presence of companions with the patients [3,4]. Conventionally, physician training focuses on an encounter between two people: the patient and the physician. In practice, a third person (a companion) frequently accompanies a patient during a medical encounter [5]. A second adult – usually

parents or a husband or wife – accompanying the patient to the consultation is always significant and deserves the attention of the doctor. Although many consultations occur only with the patient, others involve companions with the patient in the office [6]. Routine visits in which one or more family member is present in the medical office with the patient are frequent. Overall, it is accepted that in about 30% of consultations there is a companion with the patient, usually a family member, especially in the case of elderly patients and children, who can assume important roles in improving the understanding of both the patient and doctor [7-9].

The presence of family members creates unique opportunities and challenges for the physician while interviewing the patient during

an office visit. The physician must address issues of confidentiality, privacy, and agency during consultations. Special skills are required to respectfully and efficiently involve family members, while keeping the patient at the center of the visit [10]. The major results of existing studies suggest that the presence of companions with patients in consultations is often perceived as useful, and that these companions assume a variety of roles that improve the results of the consultation and medical care [4,5,11].

However, although it is no surprise to clinicians to hear that patients often attend outpatient medical visits with a companion, for example a family member, and that this is a common phenomenon in family medicine and other medical areas, previous research on communication in medical encounters has primarily focused on dyadic interactions between the physician and patient. Consequently, even a cursory examination of the vast literature on patient-physician relationships reveals that this characteristic, and its implications for medical practice, have been sparsely studied [12,13], and very little is known about the phenomenon of the presence of a companion with the patient in the medical office.

Moreover, clinicians may also be aware that it is not uncommon the presence of a companion to be present without the patient or instead of the patient in the consultation of family medicine. But even less is known about this fact: the presence of the companion by the patient (rather than the patient). In this context, it can be assumed that: 1) the presence of a companion without the patient at the office indicates a greater severity of the patient's biopsychosocial fragility compares to the presence of a companion with the patient, and this could have practical clinical implications; 2) the importance of the ethical and legal implications of communication with the companion when the patient is not present, and this is particularly relevant in the case of a high frequency of visits by the companion alone to the family medicine consultation; and 3) the possible bias of information obtained only from the companion in the family medicine consultation.

Thus the aim of the study was to describe the frequency and characteristics of the presence of the companion with the patient and the companion without the presence of the patient in the office of family medicine in our environment, and to assess their practical clinical implications.

Materials and Methods

An analytical observational study, which included patients of both sexes over 14 years old, was conducted (family doctors attend patients over 14 years old in Spain). The sample size calculation was performed taking as variable comparison the "number of chronic diseases of companion" Assuming a confidence level of 95%, a power of 80%, a ratio cases/controls 2: 1, and a standardized mean difference 0.6. So, it would be needed 34 cases and 68 controls [14].

The location was a family medicine office, in the Health Center Santa Maria de Benquerencia, Toledo, Spain, which has a list of 2,000 patients.

From a randomly chosen day for 15 consecutive days, from 26 November 2015 to 18 December 2015, the visited patients were included, and data from the companions with patients and from

companions who were there without the presence of the patients at the office, were collected. Companion was defined as any person who accompanied the patient in the consulting room or that consult instead the patient.

Patients were included only one time. Thus, were excluded the repeated consultations of same patient, including only the first visit.

For each patient and companion the following variables were collected: presence or absence of the patient at the medical office, age, sex, chronic disease (defined as "any alteration or deviation from normal that has one or more of the following characteristics: is permanent, leaves residual impairment, is caused by a non-reversible pathological alteration, requires special training of the patient for rehabilitation, and / or can be expected to require a long period of control, observation or treatment") [15], classified according to International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10) [16], taking medication, classified according to the ATC (Anatomical Therapeutic Chemical classification code or system [17,18], amount of sick leave taken by the patient, potential familial problems in the patient context based on the genogram, social-occupancy class, according to the Registrar General's classification of occupations and social status code [19,20], chief complaint according to ICD-10, whether an analytical or imaging test was requested for the patient, whether the patient need a consultation with a specialist, the companion relationship to the patient, and the social availability of the companion in relation to the patient.

A Microsoft Excel® file was built, and the Statistical Package for the Social Sciences® (SPSS) software [21] was used. Descriptive data, which were expressed by standard measures of central tendency and dispersion, were obtained. The bivariate comparisons were performed using the chi-square test, with Yates correction when it was pertinent, for the percentages, the Student t-test for the mean, Fisher's exact probability test and the Mann-Whitney test for comparing means in variables with nonparametric distribution. Finally, an analysis using logistical regression was performed with the "Enter" method, including the variables that showed statistical significance in the bivariate analysis

The informed consent of all patients or their guardians for using their data in research was obtained.

Results and Discussion

Figure 1 shows a flowchart of the study. During the 15 days of data collection, 445 patients were included, of whom 106 presented with a companion or the companions were there without the patient's presence (23% total frequency or prevalence of the presence of a companion).

Of the 106 patients with a companion 67 (63%) were companions with patients present in the consultation, and 39 (37%) companions were there without the patients (Figure 2). There were 108 companions accompanying 106 patients (an average of 1.02 ± 0.13 companions per patient).

The study objective was to assess the practical implications of the presence of a companion with or without the patient in the consultation at the medical office. We found a high frequency of the

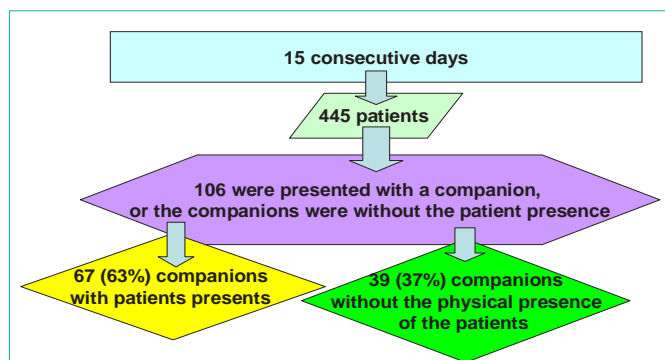


Figure 1: Study Flowchart.

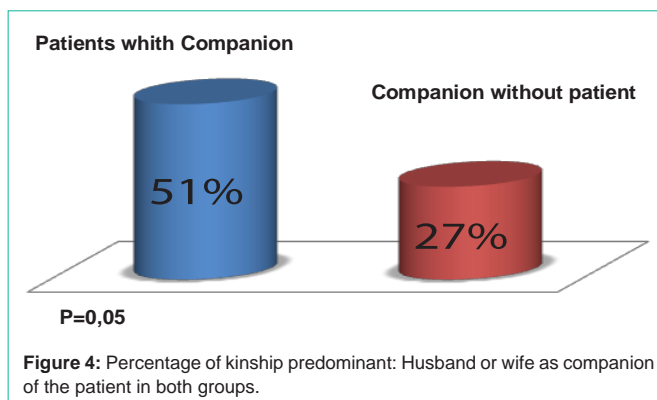


Figure 4: Percentage of kinship predominant: Husband or wife as companion of the patient in both groups.

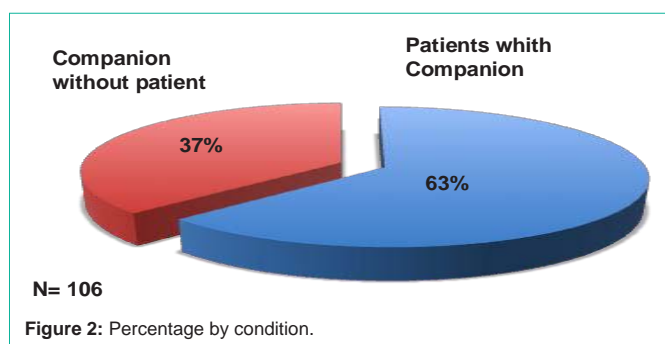


Figure 2: Percentage by condition.

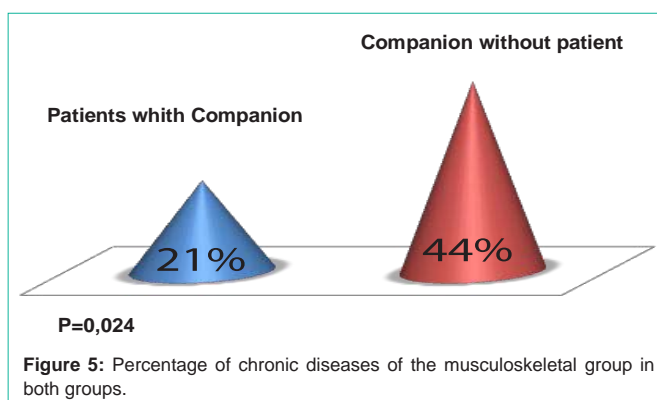


Figure 5: Percentage of chronic diseases of the musculoskeletal group in both groups.

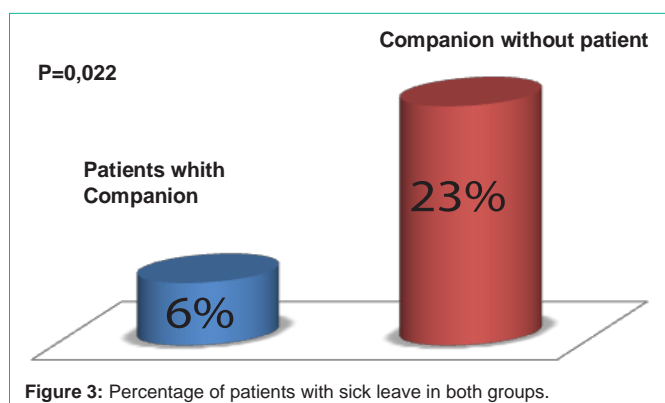


Figure 3: Percentage of patients with sick leave in both groups.

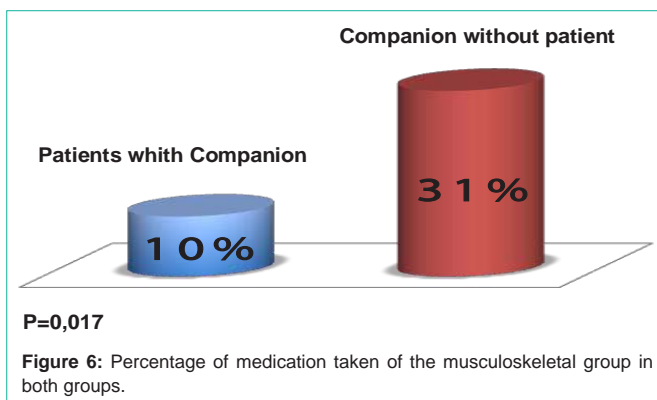


Figure 6: Percentage of medication taken of the musculoskeletal group in both groups.

companions who attended the family medicine consultation without the presence of the patient (37%). Other research studies show similar figures [22].

In addition, our study shows that the presence of a companion with the patient, compared to the visit of the companion without the presence of the patient, was associated only significantly with less patients on sick leave [6% vs. 23.1%. $p = 0.022$ (Yates)] (Figure 3). The companions with patients were predominantly the wife or husband of the patient [50.8% vs. 27.5%; $p = 0.057$] (Figure 4). The companions had fewer chronic diseases of the musculoskeletal group [21.1% / 0.21 ± 0.41 vs. 43.6% / 0.54 ± 0.68 , $p = 0.024$ (X^2)/ $p = 0.012$ (U)] (Figure 5); and were taking less drugs of musculoskeletal therapeutic group [10.5% / 0.11 ± 0.31 vs. 30.8% / 0.36 ± 0.58 , $p = 0.017$ (X^2) / $p = 0.011$ (U)] (Figure 6).

Table 1 presents the results of the variables in the patients studied, comparing the patients that were present with a companion with

patients who were not present and so their companions were alone in the family medicine office.

Table 2 presents the results of the variables studied with the companions, comparing the patients that were present with a companion, and patients that not were presents and so their companions were alone at family medicine office.

In the logistical regression analysis with the variables that showed statistical significance in the bivariate analysis (relationship - husband / wife, number of chronic diseases of musculo-skeletal system and number of consumed drugs of the musculo-skeletal system), and using as the dependent variable "the patient is present in consulting room", significant differences were found in relatives (husband / wife), who has shown a O.R. of 2,701 (i.e., if the companion is the spouse of the patient, the patient's odds of presence increases 2,701 times). The

Table 1: Results of the variables in the patients studied, comparing the patients that were present with a companion, and patients who were not present and so their companions were alone at the family medicine office.

STUDIED VARIABLES PATIENTS	PATIENTS WITH COMPANION (N=67)	PATIENTS WITH COMPANION ALONE (WITHOUT PATIENT) (N=39)	SIGNIFICANCE
Age in years of patients	51,95 ± 22,03 < 40 years 28,4% 40-64 years 37,3% ≥ 65 years 34,3%	57,87 ± 23,13 < 40 years 30,8% 40-64 years 23,1% ≥ 65 years 46,2%	t=1,305 (p=0,195) X ² =2,49 (p=0,313)
Sex of patients	Male 46,3% (33,99-58,88) Female 53,7% (41,12-66,00)	Male 30,8% (17,02-47,56) Female 69,2% (52,43-82,98)	p=0,152
Chronic diseases in patients	X; % 2,37 ± 1,47 (0: 9%; 1: 25,4%; 2: 19,4%; 3: 20,9%; 4: 16,4%; 5: 9%)	X; % 2,41 ± 1,58 (0: 2,6%; 1: 30,8%; 2: 30,8%; 3: 10,3%; 4: 17,9%; 5: 5,1%; 8: 2,6%)	N.S
Medications taken by the patient	2,90 ± 3,11 (0: 22,4%; 1: 25,4%; 2: 13,4%; 3: 6%; 4: 9%; 5: 3%; 6: 4,5%; 7: 7,5%; 8: 1,5%; 9: 3%; 10: 1,5%; 12: 3%)	3,08 ± 2,91 (0: 15,4%; 1: 33,3%; 2: 2,6%; 3: 15,4%; 4: 5,1%; 5: 2,6%; 6: 7,7%; 7: 7,7%; 8: 5,1%; 9: 2,6%; 10: 2,6%)	N.S.
Patients with sick leave	6% (1,65-14,58)	23,1% (11,13-39,32)	p=0,022 (Yates)
Potential problems familiar context of the patient based on the genogram	(n=64) 42,2% (29,93-55,18)	(n=38) 50% (33,37-66,62)	N.S.
Social-occupancy class of patients			
Higher managerial	1,6%	2,6%	
- Intermediate occupations	0	0	
-Specialized white-collar-workers	6,3%	2,6%	N.S.
-Specialized-workers manuals	6,3%	7,7%	
-semiskilled workers	15,9%	17,9%	
-Unskilled workers	55,6%	59%	
-Students	14,3%	10,3%	
Complaint of patient according to ICD-10 *	IX: 17,9% X: 16,4% V: 11,9% XIII: 10,4%	IX y XIII: 20,5% X: 10,3% IV, V, XI y XIV: 7,7%	N.S.
Analytical test was requested for the patient	4,5% (0,93-12,53)	2,6% (0,06-13,47)	N.S.
Imaging test was requested for the patient	1,5% (0,03-8,03)	0	N.S.
The patient need a consultation with the specialist	23,9% (14,30-35,86)	7,7% (1,61-20,87)	p=0,064

*IV.-Diseases of the respiratory system; V.-Diseases of the digestive system; VI.-Diseases of the skin and subcutaneous tissue; VII.-Diseases of the eye; VIII.-Diseases of the ear and mastoid process; IX.- Diseases of the circulatory system; X.-Diseases of the respiratory system; XI.- Diseases of the digestive system; XIII.-Diseases of the musculoskeletal system and connective tissue; XIV.-Diseases of the genitourinary system.

other two variables showed no statistically significant differences with performing logistic regression. The final model is shown in Table 3.

Therefore, the main finding of our study is that there are no significant differences (discounting inconsistent relationships) either between patients or their companions, whether patients are present or absent. The implication for clinical practice is that the relevant value to the family doctor, in relation to the complaint, workload, chronic disease, drugs, and social and family problems, is the presence of a companion, regardless of whether the patient is present or not in the consultation. That is, accepting that the presence of a companion in the office of family medicine is a significant event with a semiotic meaning that the doctor must take into account [3-5], the presence or absence of the patient with the companion has no diagnostic value per se, the latter residing solely with the "companion."

You might think that the presence of a companion without the presence of the patient may have some semiotic significance, such as the increased severity of the patient's biopsychosocial fragility,

compared to when the patient and companion are both present at the family medicine office. We found no evidence to validate this hypothesis. Our study shows that the family doctor should be aware of the presence of a companion or family member of the patient, whether the patient is present or not.

We found that the spouse is the most common kinship in both groups (Figure 4), which coincides with most studies [4,23-25]. In addition, the likelihood that the patient is present in the consulting room is greater, significantly, only when the companion is the husband / wife of the patient (Table 3).

The companions can play a complex and sometimes ambivalent role. The presence of the companion, without the patient, as a source of information about the patient's disease can cause false positives and negatives that may have serious consequences. The companion may express concern or reassurance about the health status of the patient, favoring labeling the patient with a certain disease (e.g. mental illness) and requesting tests and treatments for the patient (not present), so

Table 2: Results of the variables in the companions studied, comparing the patients that were present with a companion, and patients who were not present and so their companions were alone at the family medicine office.

STUDIED VARIABLES COMPANIONS	PATIENTS WITH COMPANION (N=67)	PATIENTS WITH COMPANION ALONE (WITHOUT PATIENT) (N=39)	SIGNIFICANCE
Age in years of companions	(n=60) 50,85 ± 15,43 < 40 years: 23.3% 40-64 years: 55% ≥ 65 years: 21,7%	(n=39) 53,05 ± 12,60 < 40 years: 15,4% 40-64 years: 69,2% ≥ 65 years: 15,4%	N.S.
Sex of companions	(n=62) Male 43,5% (30,99-56,74) Female 56,5% (43,25-69,09)	(n=40) Male 27,5% (14,60-43,88) Female 72,5% (56,11-85,39)	N.S.
The companion relationship with the patient	(n=61) Mother: 16.4% Father: 6.6% Brother: 0 Another familiar: 0 Friend: 1.6% Son: 23% No family member: 1.6% Husband / Wife 50.8%	(n=40) Mother: 20% Father: 7,5% Brother: 2,5% Another familiar: 7,5% Friend: 0 Son: 35% No family member.: 0 Husband / Wife: 27,5%	p=0,057
Chronic disease in companions	(n=57) 2,07 ± 1,51 (0: 15,8%; 1: 21,1%; 2:28,1%; 3: 22,8%; 4: 3,5%; 5: 5,3%; 6: 3,5%)	(n=39) 1,95 ± 1,60 (0:23,1%; 1: 25,6%; 2: 7,7%; 3: 28,2%; 4: 10,3%; 5: 2,6%; 6: 2,6%)	N.S.
-Diseases of the musculoskeletal system and connective tissue*	21,1% / 0,21 ± 0,41	43,6% / 0,54 ± 0,68	p=0,024 (X2) / p=0,012 (U)
Medications taken by the companion	(n=57) 1,63 ± 1,96 (0: 40,4%; 1: 19,3%; 2:15,8%; 3: 7%; 4: 7%; 5: 3,5%; 6: 5,3%; 7: 3,5%)	(n=39) 1,95 ± 2,61 (0:43,6%; 1: 12,8%; 2: 17,9%; 3: 5,1%; 4: 7,7%; 7: 7,7%; 8: 5,1%)	N.S.
-Musculo-skeletal system*	10,5% / 0,11 ± 0,31	30,8% / 0,36 ± 0,58	p=0,017 (X2) / p=0,011 (U)
Potential problems familiar context of the companion based on the genogram	(n=56) 42,9% (29,71-56,78)	(n=39) 53,8% (37,18-69,90)	N.S.
Social-occupancy class of companions	(n=53)	(n=39)	
Higher managerial	0	0	
- Intermediate occupations Intermediate occupations	1,9%	2,6%	
-Specialized white-collar-workers	1,9%	7,7%	
-Specialized-workers manuals	9,4%	7,7%	N.S.
-semiskilled workers	24,5%	17,9%	
-Unskilled workers	58,5%	59%	
-Students	3,8%	5,1%	
The social availability of companion in relation to the patient	(n=58) Workers: 29.3% Retired: 25.9% Students: 3.4% Housewife: 29.3% Unemployed: 12.1%	(n=40) Workers: 47.5% Retired: 17.5% Students: 5% Housewife: 25% Unemployed: 5%	N.S.

*In Chronic diseases in Patients and Medications taken by the patient only statistically significant comparisons are shown.

the family doctor should be vigilant with regard to this information, and validate it by triangulation with that provided from other sources, and certainly from the own patient themselves [26-30].

The other important result of our study is the high presence of companions without patients at consultation (37%) (Figure 2), which, although consistent with other studies [22], should make us consider the ethical and legal aspects of companions in the office [10].

The ethics of confidentiality is an important issue when we have to talk to family and friends about the disease of an adult (even if a "minor responsible") [31]. On the other hand, democratized societies have accepted the right of freedom on a basic principle of coexistence, which is translated into practice in the principle of autonomy: the patient is free and has the ability to decide on their future; this means

it has to be he or she who decides about their treatment. Here a problem arises: How can you make medical decisions without the presence of the patient? Sometimes the patient – without being mentally disabled – is unable to make a certain type of decision, because of a certain pressure, or trauma, or simply because he or she cannot travel to the medical office. This is when the family doctor has to act as a "psychologist" and make the correct decision [32-36].

The medical act is the personal relationship established between a doctor and a patient, born of an equity link. The medical act, in which the doctor-patient relationship is concrete, is a special form of relationship between people: usually, one of them (the patient) comes to the office motivated by a change in their health, or the other (the doctor) who is able to guide and heal, according to their preparation

Table 3: Variables model final of equation regression logísticos.

Variables in the equation		B	E.T.	Wald	gl	Sig.	Exp(B)
Step 1a	PARACOMPESOSO	,994	,475	4,367	1	,037	2,701
	NUMENFCRONACOMPGXIII	-,788	,458	2,962	1	,085	,455
	NUMEDICACOMPGM	-,931	,573	2,639	1	,104	,394
	Constante	,450	,313	2,066	1	,151	1,569

a.-Variables entered in Step 1: PARACOMPESOSO (relationship - husband / wife), NUMENFCRONACOMPGXIII (number of chronic diseases Musculo-skeletal system), NUMEDICACOMPGM (number of consumed drugs group Musculo-skeletal system).

and the type of disease that the patient has. Thus, the obligations and duties of the physician include, among others: professional secrecy, appropriate technical information and consent, duty of care and continuity of care, and assistance and advice [37]. The doctor-patient relationship should be made with the individual patient and not with the companion of the patient (family). And likewise, explanations should be given to the patient, rather than the companion, because you cannot leave out of this relationship to the patient, who is the one who will be directly affected by the doctor's decision [38]. In frequent visits where the companion is at the office of family medicine without the presence of the patient, all these ethical and legal problems arise.

On the one hand, we have to perform the treatment being loyal to our patient, and to consider them first, but without forgetting that he or she is into a context, mainly in a familial context. This family context is an important feature of family practice and influences the processes of patient care, and the representative of this context is the companion, who can also be very useful in assistance and patient care [4,5,11]. The companions assume a variety of roles to improve the results of the consultation and medical care. The presence of a companion, especially if there is a serious health problem, can be critical to help or intervene with the success of the successive visits [9,39,40].

It is proposed to make a patient-centered medical care, but it really should be a patient-centered care with a companion [41-43]. Previously reported differences in accompanied versus unaccompanied visits may reflect patients' preferences for being accompanied, the role they wish their companion to play, and the patients' health status. Being accompanied by a family member or friend does not result in less attention being paid to patients' concerns [44]. Companions sustain the patient and share information without reducing the level of patient involvement [45-47].

Among the limitations of our study, we should mention that the main result found of no significant relevant differences between patients or companions when the companion is present with the patient compared to the companion attending the family medicine consultation without the patient being present can be regarded as a "negative result" [48]. But this "negative result" of our study can improve clinical practice: the relevant diagnostic value to the family doctor is the presence of a companion, whether the patient is present or not in the office. To know that the presence or absence of the patient with the companion in the family medicine consultation is not per se of semiotic value, which falls on the "companion," is as important for practical purposes as if significant differences had been found.

It could be considered that our study is "small" (even if it satisfies the statistical requirements of sample size). Empirical evidence confirms the importance of "small" studies: when the results of small studies are compared with those of large trials, the results are usually consistent, and when inconsistencies are detected, they appear to be related to "publication bias" that affects negative studies [49]. Possible future lines of research could be: 1) geographical variations and international reality (because the reality described in our study, i.e. the high frequency of the presence of a companion without the patient in the family medicine office, is in a European and Mediterranean context), and that cannot be reproduced in other contexts, such as Anglo-Saxon or Americans, in the same way that it has been described that interaction patterns in Taiwanese medical interviews differ from Western patterns [50]; 2) changes in communication in medical-companion relationships. Just as the presence of a third person in the medical encounter changes the dynamics of interaction in the medical interview and may influence the development of a trusting and effective physician-patient relationship [51], so too the presence of a companion alone, without the presence of the patient, probably changes the dynamics of communicative interaction with the patient and companion, and maybe also with the family (this may require a qualitative and quantitative approach).

Conclusions

In summary and conclusion, despite the absence of data relating to the international situation in this field, as many studies refer to visits with specialists (as in the geriatric field or oncology), it seems that the importance of a companion is greater in family medicine compared to other areas of medicine, because it involves more communicative-relational complexity; however, it is little studied and doctors do not feel trained enough to deal with the issue [22,52]. We found that 1) there is a high frequency of companions without the presence of the patient in the medical office, which has ethical and legal implications; and 2) after discarding inconsistent relations, there is no relevant difference between patients or companions according to be present or not the patient at the medical office. The likelihood that the patient is present in the consulting room is greater, significantly, only when the companion is the husband / wife of the patient. This "negative result" is "positive" for clinical practice, since the diagnostic value for the family doctor should lie with the "companion," whether or not the patient is present.

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