



## Communication Study

# “Speaking-for” and “speaking-as”: Pseudo-surrogacy in physician–patient–companion medical encounters about advanced cancer



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## ABSTRACT

**Objective:** To examine using audio-recorded encounters the extent and process of companion participation when discussing treatment choices and prognosis in the context of a life-limiting cancer diagnosis.

**Methods:** Qualitative analysis of transcribed outpatient visits between 17 oncologists, 49 patients with advanced cancer, and 34 companions.

**Results:** 46 qualifying companion statements were collected from a total of 28 conversations about treatment choices or prognosis. We identified a range of companion positions, from “pseudo-surrogacy” (companion speaking as if the patient were not able to speak for himself), “hearsay”, “conflation of thoughts”, “co-experiencing”, “observation as an outsider”, and “facilitation”. Statements made by companions were infrequently directly validated by the patient.

**Conclusion:** Companions often spoke on behalf of patients during discussions of prognosis and treatment choices, even when the patient was present and capable of speaking on his or her own behalf.

**Practice implications:** The conversational role of companions as well as whether the physician checks with the patient can determine whether a companion facilitates or inhibits patient autonomy and involvement. Physicians can reduce ambiguity and encourage patient participation by being aware of when and how companions may speak on behalf of patients and by corroborating the companion’s statement with the patient.

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## 1. Introduction

While the “physician–patient relationship” is given primacy in both research literature and public discourse, this dyadic view represents an incomplete understanding of the modern medical encounter. Routine adult medical encounters in the USA are accompanied between 20% and 66% of the time, with patients who are older, sicker, female, and less educated being more likely to be accompanied [1–4].

Third-parties during medical encounters have been perceived in a range of ways, from disruptive interlocutors, to beneficial social, linguistic, and cognitive extensions of the patient [2,4–7]. Previous research has suggested that companions can play an influential or even dominant role in medical conversations [8,9]. Certain patients in certain clinical contexts may find extensive companion participation beneficial. In ideal circumstances, an intimate companion can create a “shared mind” with the patient. In such circumstances, open communication helps the patient and companion to bring a wider range of experience and cognitive resources, enhances the patient’s ability to successfully navigate an arduous medical journey, and promotes relational autonomy [10–12].

Some studies, however, have implicated companion presence as an inhibitor to patient-centered care. In one study, a majority of physicians surveyed reported that companions were sometimes a

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barrier to shared decision-making [13]. Analysis of recordings and transcripts of actual encounters supports this physician perception. Green [14] found that patients who were accompanied raised fewer conversational topics and participated less often in decision-making. Tsai [15] found that when Taiwanese patients were accompanied, they volunteered less information to physicians. Wolff [2] concluded that multiple studies have indicated accompanied patients are less verbally active and discussion is shifted toward biomedical information-giving and away from psychosocial exploration.

This mixed literature on physician–patient–companion visits is concerning because in order to preserve autonomy, the patient must maintain enough conversational control to broadly understand the biopsychosocial situation he or she faces and to make decisions without coercion [16].

Companion influence on the medical encounter and shared decision-making is particularly salient in the context of serious and life-limiting illnesses. Accordingly, we undertook a secondary analysis of a set of audio-recordings between patients with advanced cancer, their companions who were present in the consultation and their oncologists. In particular, we focused on high-stakes discussions about prognosis and treatment choices; these tend to be emotionally charged, difficult conversations that often influence subsequent quality of life. Building on work by Coupland [8], we chose to look at both syntactical (e.g. use of “we”, “him/her” and/or “you” when referring to the patient) and interactional (e.g. to whom questions and information was addressed) behaviors to understand the conversational role taken by companions in triadic clinical encounters.

## 2. Methods

### 2.1. Study design

This was a qualitative study utilizing a dataset of transcribed medical encounters between patients with advanced cancer, their companions, and their oncologists. Transcriptions were chosen to preserve anonymity of the physicians, whose voices might otherwise be recognized by study personnel. Non-verbal participation and other actions that could be not transcribed from audio recording were not analyzed in this paper. The data used in this study are from the observational phase of a larger randomized trial (R01CA140419) of an intervention to improve clinical communication [17]. The study was approved by the five relevant institutional review boards.

### 2.2. Physician participants

Oncologists were recruited to provide three audio-recorded clinical encounters with patients identified as having advanced cancer. Practicing oncologists in the greater Rochester, NY and Buffalo areas who were currently caring for patients with solid (non-hematologic) malignancies were eligible for the study. Recorded encounters used in this analysis took place between November 2011 and March 2012.

### 2.3. Patient participants

Potentially eligible patients were identified from the office visit schedules at participating physicians' practices by a research assistant in collaboration with the physician or a practice nurse. With the physician's permission and patient's assent, potentially eligible patients were approached by a research assistant who described the study and obtained informed consent. Patients were eligible if they were age 18

or older, had advanced non-hematologic cancer (stage III or IV), were able to understand spoken English and complete surveys, and for whom the oncologist “would not be surprised” [18] if the patient died within 12 months.

### 2.4. Coding and analysis

We used a grounded theory approach to analysis [19], applying a coding/editing template method to the transcribed audio-recordings as described by Crabtree [20]. Each companion utterance in the transcriptions was initially reviewed by one author (BM). If a companion utterance was deemed to be part of a discussion about either prognosis or treatment choices, the entire discussion was read and coded. From these conversational samples, all statements by companions that in some respect appeared to “speak on behalf of” the patient were identified. Patient–physician conversations about topics other than prognosis and treatment, and conversations that took place without companion participation were not specifically coded or analyzed.

The multi-disciplinary analytic team collectively reviewed the transcripts. Collectively, the team developed a taxonomy of companions' utterances categorized as speaking on behalf of a patient and a consensus was reached about the correctness of each categorization. Then the team developed a mutually-exclusive coding scheme to further characterize the companion's utterances. The process of developing the codes was informed by prior research on triadic communication, in particular, Coupland [8], who utilize the terms ‘speaking for’, ‘speaking with’, ‘speaking as’, and ‘co-experiencing’ to describe companion communication for elderly patients. In addition to adapting these terms, our analysis yielded several other companion behaviors that could be coded reliably, each referring to a different conversational role taken by the companion. Thus, our coding system included a mixture of emergent and a priori categories. Once consensus was reached about the coding scheme, all of these segments were extracted and coded by two members of the team. Examples and details of the coding process are available from the authors.

Once the actual utterances were coded, three additional contextual elements were coded:

- (1) Was the companion's utterance spontaneous, or in response to a prompt from the physician or patient?
- (2) Did the patient express explicit agreement or disagreement with the companion's statement? Explicit agreement included utterance such as “I agree”, “That's true”, etc.
- (3) Did the physician respond to the companion's statement? Did the response express explicit validation or rejection of the companion statement? To whom was the statement addressed (patient or companion)? We also coded whether the companion's statement prompted the physician to change addressee from patient to companion.

## 3. Results

### 3.1. Physician characteristics

Of the 33 oncologists who were eligible and invited to participate, 23 enrolled and 10 declined. From the thirty-four accompanied visits in our sample, there were 17 unique physicians. The participating physicians were predominantly male (13/17) and identified as either White (11/17) or Asian (6/17). A slight majority of the physicians (9/17) had participated in communication skills training since medical school.

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