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Recognising the importance of 'family time-out' in consultations: an exploratory qualitative study

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ABSTRACT

Objectives: Patients are often accompanied by family or companions during consultations, but little is known about how this might influence the process. We explored how the presence of a companion in a consultation contributes to communication and the decision-making process.

Design: Observational study.

Setting: A teaching hospital and a district general hospital in south-west England.

Participants: 31 patients and their physicians were observed during consultations in which decisions to undergo palliative chemotherapy were made. Each patient was accompanied by at least one companion.

Outcome measures: Communication patterns between physicians, patients and companions.

Results: In addition to standard patient/physician interactions, patients and companions were often found to discuss medical information and exchange opinions between themselves without the physician actively participating. We called these instances 'family time-out'. On the occasion of disagreement between patients and companions about preferred treatment options, physicians and patients were able to agree the decision while acknowledging the differences in opinion.

Conclusions: Instances of 'family time-out' may contribute to better consultation outcomes because they are understood and supported by the patient's social system. This study highlights the potentially important role of exchanges between patients and companions during consultations and how physicians may benefit from observation of such exchanges. We recommend testing the value of making space for family time-out during consultations. Also, we recommend further study into the medical ethics of family time-out. While the focus here is on palliative chemotherapy, this finding has implications for other consultations, particularly those involving difficult treatment decisions.

ARTICLE SUMMARY

Article focus

- Patients are often accompanied by family or companions during consultations. How does the presence of a companion in a consultation contribute to communication and to the decision-making process?

Key messages

- In addition to standard patient/physician interactions, patients and companions were often found to discuss medical information and to exchange opinions between themselves without the physician actively participating; we called these instances 'family time-out'.
- Physicians may benefit from observation of such instances of 'family time-out' since these may contribute to consultation outcomes which are better understood and supported by the patient's social system.
- This finding highlights the importance of companions being encouraged to attend consultations in which difficult decisions are made.

Strengths and limitations of this study

- Strengths of this study are the use of naturally occurring data and the novel findings.
- The study is limited by only including consultations in which decisions to undergo palliative chemotherapy were made.
- It is likely that described will be relevant to other types of consultations where the treatment and postoperative recovery are likely to have a major impact on the daily lives of partners, family members and friends.

INTRODUCTION

Evidence suggests that patients are accompanied by family or companions in between 20% to almost 100% of consultations and this raises issues about how the presence of others influences the process and treatment decision.[1–7] Available research shows that companions are more frequently present in consultation with older, less healthy and less well-educated patients, and suggests that there are some practical benefits associated with companions attending a consultation such as provision of emotional support and information recall.[1 2 5 7–11] Companions may also communicate information between the

patient and the physician, and ask questions on the patient's behalf, being sometimes described as a patient advocate or watchdog.[2 3 5 7 8 12] This may lead to physicians giving more attention to concerns and topics raised by patients if consultations include significant others.[1 8 11 13] Possible drawbacks associated with the presence of companions are uncommon but include examples of companions discussing their own problems, excluding patients from the conversation with the physician or playing a more direct role than anticipated by patients.[14 15] Different methods to examine consultations with companions present have been reported, but optimally 'real-time' non-participant observation of naturally occurring events with audio or video recordings is recommended.[16]

Early studies analysing consultations with companions present have focused upon interactions between accompanied and unaccompanied patients and members of the medical team, the influence of companions on recall of medical information and distribution of discursive space (ie, share of words and lengths of turns).[2 3 12 16 17] There is, however, a lack of well-designed studies evaluating interactional episodes between the patient and physician and the contribution of companions to such episodes. Interaction analysis provides data regarding the observable dynamics of patient–companion–physician to provide a better understanding of the pathways by which companions exert influence within consultations.[18] This method may provide additional insight into communication and decision-making during consultations and can inform efforts to improve the patient–physician partnership. This method may provide additional insight into communication and decision-making during consultations and can inform efforts to improve the patient–physician partnership. The aim of this research therefore was to use interaction analysis to explore how the presence of a companion in an oncology consultation regarding palliative chemotherapy contributes to the communication process and decision-making.

METHODS

This study was conducted in the south-west of England in two hospitals: one large teaching hospital and a district general hospital. Patients with advanced non-small cell lung, pancreatic or colorectal cancer were recruited to participate in a larger qualitative study exploring patients' experiences of decision-making and treatment regarding palliative chemotherapy.[4] Patients were considered suitable for the study following the diagnosis of locally advanced (incurable) or metastatic disease and discussion by a multidisciplinary cancer team. Each patient had been given a diagnosis, information about the disease stage and knowledge that treatment would not be aimed at cure. Following this the patients had been offered an appointment to see an oncologist to discuss possible palliative therapies. Relevant patients were informed in person about the study and asked if they would be willing to discuss participation with a researcher. Those who expressed an interest were given an information leaflet. At a subsequent meeting, the researcher explained the study again and patients who agreed to participate signed the consent form prior to the consultations. At each stage it was made clear to patients that their medical care would be unaffected whether or not they took part in the study. When appropriate we provided an information leaflet, a letter of invitation and a consent form for partners and carers. The North Somerset research ethics committee approved the study (05/Q2003/46).

Forty-five patients with advanced cancer were recruited to the main study, 15 with each type of cancer. The main reasons for non-recruitment were administrative difficulties in contacting the patient because of the brief time period before their first appointment with the oncologist (n=16); refusal of patients without a clear reason given (n=11); indications of patients or spouses that the patient was too unwell or anxious to be interviewed (n=9) or patients were unsuitable for another reason, for example, elderly patients with dementia (n=6).

Relevant oncologists consented to the observation and recording of consultations. The nine oncologists who saw the patients were mixed in terms of age, experience and sex. They included four consultants and five registrars. (Further details are not given to protect confidentiality.) All consultations in the main study were audio-recorded and transcribed verbatim.[4] This paper focuses on the set of consultations where one or more companions were present.

Analysis

Principles of conversation analysis,[19–21] focusing on the interactional function of every turn in the consultation were applied from *the perspective of the study participants.* Initially the speaker and addressee of each turn in the conversation were identified and then turns in the consultation were grouped in episodes in which the same interactional parties engaged (eg, patient and companion or physician and patient). An episode was considered ended and a new one started if a transition had taken place. These episodes were identified and categorised into three main types of interaction: (1) 'Family time-out in the absence of the physician' which is the pattern of interaction between patients and their companions without the physician in the room; (2) 'Family time-out in the presence of the physician' which occurs with the physician in the room and (3) 'Consultation pattern of physician, patient and companion(s) talking together'. Category (3) has been previously described[18] but categories (1) and (2) emerged from the data analyses. The standard physician–patient interaction in the presence of a companion was also observed but is not the subject of this paper. All types of interactions were interpreted within the context of the consultation and the difficulties that companions may present to the process were also considered. Differences of opinion about the meaning of transcripts were discussed between SA and IK, and between TH and IK.

We present episodes of the consultations in boxes, indicating turns of the conversation and the verbatim text of patients, companions and physicians. Symbols are used to indicate, for example, pauses and interruptions (table 1).

Table 1 Explanation of symbols in episodes of the consultations

Symbol	Meaning
()	Pause
(3), (7)	Timed pause, indicating length in seconds
[name]	Name of a person that was removed
Text = = text	No discernible pause within turns of a single speaker
Text [text [text	Start of overlapping text
Text] Text] text	End of overlapping text
((text))	Explanation of an event, eg, the physician leaving the room
text	Underlined text is pronounced louder
TEXT	Underlined text in capitals is pronounced even louder

RESULTS

The main study recorded 39 consultations of which 31 (80%) included at least one companion and form the basis of this paper (see table 2). Companions were most often the patient's partner (n=25), with adult children, siblings or an ex-partner also attending (n=8, 2 and 1, respectively). The participants, of whom 21 were male, ranged in age from 44 to 79 years and had been diagnosed with advanced non-small cell lung (n=9), pancreatic (n=11) and colorectal cancer (n=11).

Family time-out in the absence of the physician

It was observed that 'family time-out' naturally occurred when the physician left the room. The audio-recording continued during such instances and analyses showed that family members often used the occasion to discuss the information received and check family members' and patient's understanding and treatment preferences.

During the consultation with Mrs 342 and her husband (table 3), the physician proposed chemotherapy

Table 2 Patient characteristics and companions present

Patient	Sex	Site	Age	Relatives present	Treatment decision
301	M	L	65	Wife	Chemotherapy offered and accepted
302	F	P	57	Husband	Chemotherapy offered and accepted
303	F	CR	69	Husband	Chemotherapy offered and accepted
304	F	CR	71	Husband	Chemotherapy offered and accepted
309	M	L	63	Wife	Chemotherapy offered and accepted
311	F	L	64	Husband	Chemotherapy offered and accepted
312	F	L	68	Husband	Chemotherapy offered and accepted
313	M	P	71	Wife, son	Patient too ill for chemotherapy, steroids offered and accepted
315	M	P	57	Wife	Chemotherapy offered and refused
316	M	CR	57	Sister	Chemotherapy offered and accepted
318	M	CR	63	Wife, daughter	Patient too ill for chemotherapy, steroids offered and accepted
319	M	CR	73	Wife	Patient refused chemotherapy
320	F	L	74	Husband	Chemotherapy offered and accepted
321	F	P	72	Son	Patient too ill for chemotherapy
323	M	P	72	Wife, daughter, son	Chemotherapy offered and accepted
324	M	CR	68	Wife	Chemotherapy offered and accepted
325	M	CR	44	Ex-wife	Chemotherapy offered and accepted
327	M	CR	65	Wife	Patient refused chemotherapy
331	M	P	75	Wife	Chemotherapy offered and accepted
332	F	P	54	Sister	Patient too ill for chemotherapy, antibiotics offered and accepted
333	M	CR	77	Two sons	Patient too ill for chemotherapy, care through hospice to continue
335	M	CR	79	Wife, son	Chemotherapy offered and accepted
336	M	P	50	Girlfriend	Chemotherapy offered and accepted
337	M	P	73	Wife	Chemotherapy offered and accepted
338	M	L	53	Wife	Chemotherapy offered and accepted
339	M	P	61	Wife	Chemotherapy offered and accepted
341	M	CR	64	Wife, daughter	Chemotherapy offered and accepted
342	F	P	69	Husband	Chemotherapy offered and refused
343	M	L	59	Wife	Chemotherapy offered and accepted
344	M	L	73	Wife	Chemotherapy offered and accepted
346	F	L	64	Daughter	Chemotherapy offered and accepted

CR, colorectal cancer; L, lung cancer; P, pancreatic cancer.

treatment, either as a single therapy or in combination with radiotherapy. The patient was hesitant because of the uncertain survival benefits of treatment and the impact on quality-of-life and she asked the physician if she could 'think on that' (turn 01). When the physician was outside the room getting written information about the therapy, the patient asked her husband whether he agreed with her decision (turn 08). Although he did not explicitly disagree with her (turns 11 and 13), the patient's response indicated that she experienced it as such: 'Can you see my point of view?' (turn 14). Although there was no agreement at this stage, there was a working towards a decision together: 'Do you know what I mean?' (turn 20) and 'You can see my point of view can't you' (turn 22). The family time-out ended with the return of the doctor. Both before and after the time-out only the patient talks with the doctor about the treatment decision but she has used the time-out to ascertain whether her husband agrees with her. The way the patients and companions use the time in which the doctor is absent would obviously not have been possible if the patient had been unaccompanied.

Family time-out in the presence of the physician

'Family time-out' also occurred in the presence of the physician. Table 4 gives two examples. The first fragment (Mrs 346) shows how the patient creates a 'family time-out' in the presence of the physician to check with her companion, in this case her daughter, whether her treatment preference is shared or at least supported. The physician offered palliative chemotherapy as a treatment option which was accepted by the patient. While the physician was completing a consent form the participants remain silent for 10 s. A family time-out was smoothly inserted into the consultation when the patient used this occasion to ask her daughter whether she was all right with 'all this' (turn 04). The daughter responded that her mother was the one to decide (turn 05). This was received with a hesitant, 'mm' by the patient (turn 06). Apparently sensing that her mother was not satisfied, the daughter repeated her statement and added that she was not going to stop her mother (turn 07), giving the impression that she did not agree with her mother's decision. In turn 08 the patient implicitly acknowledged this

Table 3 Family time-out in the absence of the physician

Turn		
Consultation of Mrs 342, with her husband		
01	Patient:	Can I can I think on that?
02	Physician:	You most certainly can.
03	Patient:	And I will discuss it with my how would I let you know?
04	Physician:	Right well let me give you some written information about the drugs =
05	Patient:	Yes
06	Physician:	= so I'll go and get that now and then we'll negotiate how we can get in contact.
07	Patient:	Yes ok
((Physician leaves the room))		
08	Patient:	Do you agree with my decision as well?
09	Husband:	Well it's
10	Patient:	We'll go home and discuss it.
11	Husband:	Yeah. It's up it's entirely up to you =
12	Patient:	Yes I know
13	Husband:	= because you're the one that's got to live with it.
14	Patient:	I know but if it's just go () I don't think I I don't (.) can you see my point of view?
15	Husband:	Yeah
16	Patient:	If I got to go all through that and I'm ill and it's only going to give me another 6 months so all together I've only got just over a 12 month haven't I?
17	Husband:	Yeah er 14 months actually.
18	Patient:	Yeah yeah 14 months at the most. Up to 8 months I could go living like this.
19	Husband:	Yeah.
20	Patient:	Do you know what I mean?
21	Husband:	Yeah I know what you mean. That's right yeah yeah yeah.
22	Patient:	Yeah. You can see my point of view can't you? Yeah.
23	Husband:	And it's and it's like I was saying to you out there like. Although I know what I've understood what you've said
24	Patient:	Yeah.
((A number of turns deleted))		
((Physician re-enters the room))		
25	Physician:	There we are.
26	Patient:	Ok. Thank you very much.
27	Physician:	Is there anything else you want to ask me about it?

Table 4 Family time-out in the presence of the physician

Consultation of Mrs 346 with her daughter		
01	Physician:	All right. I need to do a consent form
02	Patient:	Yes
03	Physician:	and then I'll go through that with you and then if you sign that that allows me to book the treatment and then we'll give all the forms to the oncology day unit and they'll contact you probably tomorrow or possibly later this afternoon. And er then we'll get things organised
((turns deleted of small talk while the physician completes the forms))		
04	Patient:	(10) Are you all right with all this (name of daughter)? Do you think I'm (.) it's the right thing to do ().
05	Daughter:	It's your decision you
06	Patient:	Mm.
07	Daughter:	It's your decision. I'm hardly going to turn round and say no best not do it.
08	Patient:	I know but I'd rather you (.) you were with me.
09	Physician:	Well if we go down this route it's always on the understanding that if you feel () if it doesn't feel right at any time or we don't think it's right for you you don't need to ().
10	Patient:	What will happen if if the chemotherapy it doesn't doesn't work or it's not suitable?
Consultation of Mr 335, with his wife		
Turn		
01	Wife:	But you haven't got much of an appetite either have you? Will that make any difference to this treatment?
02	Physician:	No not particularly. If you haven't got much of an appetite one of the things we can give steroids. And that can sometimes boost your appetite a bit.
03	Wife:	Well you've been feeling a bit sick haven't you and the doctor's given you some tablets to stop that nausea feeling
04	Patient:	That's right yeah.
05	Wife:	And er
06	Patient:	Which are
07	Wife:	you have eaten a few things better.
08	Patient:	been working yes. Eaten a little bit more since haven't I?
09	Wife:	A bit better. And we'll see what happens with that as it goes on. You don't want steroids do you?
10	Physician:	Quite a quite a lot of (name of hospice nurse)'s patients have steroids.
11	Wife:	Oh do they?
12	Physician:	Yeah. They have them. It does quite improve just general wellbeing.
13	Wife:	Oh well.
14	Physician:	But he can you know can have that in the future.
15	Patient:	Right

message by indicating that she would rather have her daughter supporting her. The 'time-out' ended when the physician joined in (turn 09), assuring the patient and possibly her daughter, that the patient could stop the therapy at any time she wanted.

The second example in table 4 concerns Mr 335, accompanied by his wife and son. The patient's wife wondered whether his lack of appetite would make a difference to his treatment (turn 01). The physician said this was not the case and suggested the use of steroids to boost the patient's appetite (turn 02). The patient and his wife then started a time-out to discuss how the patient was feeling sick and was given tablets (turns 03 and 04), which were working (turns 06 and 08), resulting in the patient eating a bit better (turns 07 and 09). When the patient's wife seemed to conclude that her husband did not want to take steroids (turn 09), the physician intervened and ended the time-out by remarking that taking steroids was quite usual (turn 10), and that it also improved well-being (turn 12). These remarks, which show that the physician had been listening, made the patient's wife reconsider the possibility (turn 13). The physician's suggestion to decide about steroids later (turn 14) was received with agreement by the patient (turn 15).

The examples in table 4 suggest that 'family time-out' in the presence of the physician has the added benefit that the physician can monitor whether the family members possess the information they need and can provide more input if required. It is also noted that the instances of 'family time-out' were integrated very smoothly in the overall consultation interactions. In the whole data set there are no instances in which the physician attempted to stop the family engaging in such a 'time-out'.

Detrimental influences of companions on consultations

The presence of companions in consultations occasionally presented challenges, for example, if there were differences of opinion between the patient and companion for a preferred treatment. When this occurred during a 'family time-out in the presence of the physician', it

Table 5 Differences of opinion

Turn		
Consultation of Mrs 304, with her husband		
01	Husband:	Right right right but if the kidney function is adequate that is what you would recommend if you were asked to
02	Physician:	That's the one we'd recommend yes
03	Husband:	Right well that's the way we've got to go.
04	Physician:	It's the way she's got to decide (what) she wants to do =
05	Husband:	(well)
06	Physician:	= it's not you decide it's she's got to decide =
07	Husband:	No but I think
08	Physician:	= what she can cope with
09	Husband:	Yeah but it's a joint thing I mean if I can help her
10	Physician:	Yes it's a joint thing BUT she's got it's she's got she's the one in the
11	Husband:	Oh yeah she's the one in the hot seat (.) absolutely
12	Patient:	in the hot seat
13	Physician:	and if she finds that the side effects are too bad =
14	Patient:	Yeah
15	Physician:	= then she can stop the treatment

provided valuable information for the physician who could intervene if appropriate.

Table 5 shows an example, where differences of opinion between Mrs 304 and her companion occurred. After having discussed treatment options, the husband checks whether he has understood correctly which option is recommended by the physician (turn 01). When this is confirmed (turn 02), the husband states that this is 'the way we've got to go' (turn 03). The physician, in response, stresses repeatedly that his wife is the one with the disease and, therefore, the one who must decide (turns 04, 06, 08 and 10). Eventually the husband concedes that indeed his wife is 'in the hot seat … absolutely' (turn 11). This is confirmed by his wife, who repeats the words 'in the hot seat' (turn 12). Once more the physician says that the patient has the final say in the treatment decision (turn 13), which is confirmed by the patient (turn 14).

DISCUSSION

This qualitative study analysed interactions in consultations between patients, companions and physicians. It demonstrates the different categories of interactions that may take place and how these may influence the consultation. 'Family time-out' interactions were observed that may take place in the absence or the presence of the physician and it is suggested that physicians need to recognise this pattern of communication and the potential advantages it may bring to the consultation. 'Family time-out' allows the participants to confirm their agreement with treatment recommendations or demonstrate decisional conflict, which when observed by the physician provides an opportunity for intervention, clarification and further discussion as necessary. This highlights the importance of companions being encouraged to attend consultations in which difficult decisions are made and it suggests potential benefits of training physicians to recognise and use 'family time-out' appropriately.

The importance of the role that companions play in consultations, and in the 'patient work' required for treatments, has hitherto received little systematic attention in the literature despite the observation in this study and others that most oncology consultations include at least one companion.[1–4] It is possible that this has not previously been studied because of concerns about the extra time required for physicians to engage with additional family members and deal with possible family disagreements during consultations.[18] Indeed, situations may occur in which companions play a disturbing role. In such cases, observing how patients and companions interact is worthwhile for the physician. If not during the consultation, this 'detrimental' influence would still occur, but without the physician observing it or having the opportunity to assist in addressing miscommunication. Training in methods to support and optimise companions' involvement in consultations may lead to better decisions for all concerned. Without companions being present in the consultation, it is possible that family discussion outside of consultations, and without medical input, may lead to misunderstandings and reduced adherence to treatment plans.

Attendance at consultations provides an opportunity for families to receive and discuss relevant information, and for the physician to check if relevant information about treatment options was understood correctly by those involved. This may also enable the physician to support family relationships, or to witness and ameliorate any 'undue influence' on the decision-making process.[22] To aid this process, physicians may consider creating opportunities for family time-out in the absence of a physician, for example, by briefly leaving the room to collect information, quietly completing forms, or implementing a short break between information giving and

decision-making to allow discussion between patients and companions while they have immediate access, if required, to medical understanding and practice. We suggest further research in this area.

Whether the physician left the room was sometimes related to, for example, questions of patients and companions. If they wanted information about, for instance, treatment options the physician might leave the room to collect this information elsewhere. Possibly the fact that questions were being asked was somehow related to the medical condition of the patient involved, but the numbers of patients in our sample do not allow statistical analyses into this. Further work would be required with a larger sample to investigate this in more depth.

The qualitative data presented here suggest a lack of opportunity within consultations for deep discussion between clinicians, patients and their family. While this may not be practicable within the context of busy oncology clinics, analyses of these critical consultations reveal that advanced communication skills and probably more time are needed to ensure that clinicians involved in reaching difficult decisions with patients and their families are equipped to provide support, information, expert advice and empathy to patients and their families facing very difficult decisions.

The study is limited by only including consultations in which decisions to undergo palliative chemotherapy were made. More research is needed in other settings to examine the reported types of companion, patient and physician interactions. It is likely that issues will be similar and relevant to other types of consultations where the treatment and postoperative recovery are likely to have a major impact on the daily lives of partners, family members and friends. In this qualitative study in two hospitals we aimed to unveil the phenomenon of companions' input into consultations. We have come to expect that optimised involvement of companions may result in decision-making that is supported by both patient and companion. This in turn may lead to improved quality of life for patients or, in cases of advanced terminal illness, improved quality of the patient's end of life. We recommend further research into ways of optimising companions' contributions.

The findings throw new light on a much debated medical ethical issue, namely the 'autonomy of the patient'. Beauchamps and Childress[23] define autonomy as the right of an individual (ie, the patient) to make his or her own choice while 'beneficence' is related to the role of the physician and is defined as the principle of acting with the best interest of the other in mind. These concepts are both potentially related to 'family time-outs'. We recommend further study into this medical ethics angle.

While there are circumstances in which patients may be regarded as autonomous individuals who should make their own decisions as independently as possible from others, this study shows that many patients consider themselves as part of a family unit. They demonstrate this by bringing companions to the consultation and, more importantly, by engaging in 'family time-out' with them. This suggests that many patients, although legally autonomous, in practice choose to involve companions in the decision-making process. In that sense 'family time-out' can be a valuable contribution in reaching the aim of 'relational autonomy', a view according to which trusting relationships can 'enhance autonomy by helping patients to process complex treatment decisions that otherwise overwhelm the cognitive capacity of a single individual'.[24] We also refer to the concept of 'shared mind' that Epstein and Street used to indicate the ways in which 'perspectives can emerge through the sharing of thoughts, feelings, perceptions, meanings and intentions among 2 or more people'. We agree with Epstein and Street that autonomy and decision-making should consider not only the individual views of patients, their relatives and healthcare staff, but also the views that emerge from their interactions.[24]

To conclude, we consider 'family time-out' an important and exciting phenomenon, which is worthwhile exploring in more depth. This might be done in larger cohorts, which will allow subcategorisation of 'family time-out' or comparisons between consultations by, for instance, physician characteristics. Furthermore, we recommend testing the value of making space for 'family time-out' during consultations. Also, we recommend further study into the medical ethics of 'family time-out'. The important question is how companions' involvement can be optimised. Important clues may be revealed by making space for, and paying attention to, 'family time-out'.

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