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## **Cover Page Footnote**

This research was supported in part by grants from the Center for Aging, University of Alabama at Birmingham and the AARP Andrus Foundation. The authors would like to thank Michelle Green, William Haley, Rebecca Silliman, William Yoels, and the anonymous reviewers for comments on an earlier draft of this manuscript.

# Satisfaction with Medical Encounters Among Caregivers of Geriatric Outpatients\*

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## ABSTRACT

*Caregivers' experiences and satisfaction with physicians and medical services provided to geriatric patients are reported. An outstanding predictor of satisfaction with physician communication and overall patient care was the extent to which caregivers were experiencing role strain. Other significant predictors included caregiver knowledge of clinic and social support services provided to patients. The data suggest that, irrespective of the quality of clinic services and physician communication style, some caregivers will be dissatisfied because their encounter is mediated by the stress of activities separate from the medical encounter. We assert the importance of specialized geriatric services and argue that if these services are not in place, caregiver satisfaction with the overall medical encounter will likely be much lower.*

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\*This research was supported in part by grants from the Center for Aging, University of Alabama at Birmingham and the AARP Andrus Foundation. The authors would like to thank Michelle Green, William Haley, Rebecca Silliman, William Yoels, and the anonymous reviewers for comments on an earlier draft of this manuscript.

This work fits within the broader context of studies focusing on the elderly patient-physician relationship (Greene, et al., 1987; Haug, 1986, 1987; Zola, 1986), and extends attention to the caregiver-physician relationship. Caregivers are dynamic participants in the patient care process (Jecker, 1990; Kapp, 1991). To examine only the patient-physician relationship ignores much of what is known about medical care services and utilization today, specifically, the fact that over two-thirds of geriatric outpatients are accompanied to the health care facility by a caregiver (Beisicker, 1991; Clair and Allman, 1993). These caregivers provide their own perspective about the patients' medical history and current health problems (Coe and Prendergast, 1985; Jecker, 1990). As the patient's health diminishes, the relationship between caregiver and physician intensifies. Given the pivotal role caregivers often play in the medical care of geriatric patients, it is important to explore the caregiver-physician relationship (Glaser, et al., 1990; Haley, et al., 1992).

The purpose of this paper is to provide data which increase our understanding of family caregivers' experiences, and their satisfaction with the medical services provided and the physicians involved in diagnosing and managing the geriatric patient's health problems. Whether or not caregivers feel integrated in the health care process through their communications with physicians is documented. This integration entails that physicians consider caregivers an important source of patient information, adequately attend to their questions, communicate in a clear manner, and spend enough time with them. Whether doctors provide sufficient time, information, and psychosocial support to caregivers should account for varying degrees of satisfaction with medical services and provider communication. Addressing these issues, most of which parallel the many problems identified by caregivers during counseling, is the focus of this paper (See Smith, et al., 1991).

### **The Caregiver-Physician Relationship**

Many researchers stress the clinical and theoretical importance of effective communication in medical encounters (Inui, et al., 1982; Mishler, 1984; Waitzkin, 1984, 1985, 1989, 1991; Woolley et al., 1978). Both empirical data and clinical experience suggest that there are important ways that physicians can maintain and enhance the health and well-being of patients, as well as family caregivers, by fostering "mutuality" through a triadic relationship (Beisecker, 1988; Clair, 1990a; Silliman, 1989).

Geriatric patients usually have a complex array of interacting biomedical, psychosocial, and functional disabilities (Silliman, 1989, 1993). Caregivers play a substantial role in assisting patients in daily activities (Radecki et al., 1988a, 1988b). In addition to the physical disabilities associated with age-related co-morbidities, many older patients have cognitive impairment that compromises their ability to exercise judgment and report symptoms and experiences. Caregivers have knowledge of the patient's physical, social, cognitive, and financial well-being, and bring this information to the medical encounter. This factor necessitates that physicians extend their learning possibilities and information-giving practices to caregivers (Haley, et al., 1992).

Research on geriatric encounters typically focuses on the many problems that exist between doctors and their geriatric patients, especially difficulties of patient communication (Adelman and Albert, 1987; Baker, 1984; Beland and Maheux, 1990; Haug and Ory, 1987; Greene, et al., 1986). Other studies call attention to problems with the elderly person's capacity for self care (Haug, 1986; Zola, 1986). Waitzkin (1991) notes that some of the most interesting and important features of research on geriatric medical encounters involve concerns about matters that appear marginal or peripheral to the technical goals of clinical medicine. He found that elderly patients' personal troubles included social isolation, financial insecurity, loss of community and material possessions, death of family members, and retirement from work. Physicians often responded to such social psychological problems by cutting off any discussion about social context and reemphasizing technical matters. At best, the current literature only implicitly addresses the pivotal role caregivers play in this relationship.

### **Geriatric Outpatient Care**

In view of the search for effective techniques to improve care for the complex and interactive health problems of the elderly, geriatric outpatient services represent promising approaches. Research on geriatric clinics documents their effectiveness in diagnosing physical and psychosocial functioning (Applegate, et al., 1991; Epstein et al., 1990; McVey et al., 1989; Rubenstein et al., 1984; Williams et al., 1987). However, it is clearly not enough for a geriatric assessment simply to diagnose physical and psychosocial functional capacities. Improved care requires input from caregivers and the results of patient assessments must be transmitted to both the patient and the caregiver (Rubenstein, 1987).

Findings from 30 years of gerontological research suggest that families have provided and will continue to provide substantial care for their aged (Borgatta and Montgomery, 1987; Brody, 1985; Clair, 1990b; Maddox and Glass, 1989; Olesen, 1989). For many patients, family caregivers are the critical link in enhancing the continuity of care, providing direct physical care, socio-emotional and financial support, and interfacing with physicians and the formal health care system as case managers (Clair, 1990a; Horowitz, 1985; Silliman, 1989).

Families typically rely on outpatient services to manage patient health problems. Many families lack basic knowledge about how to care for their relatives (Haley, et al., 1992). Caregivers often receive inadequate information about the causes, symptoms, and course of illness, as well as the availability of social support resources to deal with the problems of frail older adults.

What is apparent from the literature is that both patients and caregivers need information about their illness, its natural history, prognosis, treatment regimen, future care needs, and socioemotional support. Physician information-giving and socioemotional support are critical factors not only in deciding how to manage the patient's care, but also in caregivers' continued well-being. Concern for the caregiver beyond patient diagnosis is a challenge of "health caring" as opposed to simply "health care" (Silliman, 1989:238).

## **Method**

### **Setting**

The study site was a Veteran's Administration Regional Medical Center (VA) in the Southeastern United States. Data were gathered between July 1990 and June 1991. Subjects were selected from caregivers who accompanied patients aged 65 and older to the VA's two primary care geriatric outpatient clinics (one morning and one afternoon a week). The VA Center is affiliated with medical and nursing schools. Both clinic settings were under the direction of a general internist with certification of special competency in geriatric medicine. These clinics were staffed by attendings in primary care, rotating internal medicine residents, acting interns, nurses, a social worker, clinical pharmacist, optometrist, dietician, and clinical psychologist, with other disciplines, such as an audiologist, being consulted as needed.

## Sample

A screening strategy was used to insure that subjects were the main or primary caregiver for the patient outside the clinic setting. Caregiver participants were included in the study if: (1) they had accompanied the geriatric patient to the clinic on at least one previous occasion; (2) the patient had at least a 12-month history of current functional impairment requiring the caregiver's assistance; and (3) the caregiver had substantial responsibility for the care of the geriatric patient. The caregivers were interviewed at the clinic separate from the patient. One hundred and eight complete caregiver interviews were conducted. The participation rate was 95.6 percent. Table 1 provides a demographic profile of caregiver subjects and the patients they accompanied.

## Procedures

An interview instrument which took approximately 30 minutes to administer was developed and field tested (Haley, et al., 1992). Caregivers were interviewed individually while the geriatric patients were in the clinic room. The interviews were conducted by the senior author and a trained graduate student whose performance was monitored through intermittent observation of actual interviews.

## Measurement

The interview instrument elicited demographic and descriptive information and an assessment of patient functional capacity—activities of daily living—(Lawton, et al., 1982; see Table 1). Many patients were unable to provide information on their own functional capacities. Thus, for consistency, only caregivers' assessments were used. Caregivers have been proven to be accurate assessors of patient function (Elam, et al., 1991). Caregiver *appraisal of role strain* assessed the degree to which caregiving disrupted normal life roles and relationships. *Caregivers' social supports* distinguished both form and content of support provided to the caregiver by relatives in the last six months (Lin, et al., 1986; Sokolovsky and Cohen, 1981). Checklists of clinic procedures, recommendations and referrals to counseling, community agencies and support groups were used to ascertain a caregiver's knowledge of the medical and social support services provided to the patient.

**Table 1**  
**Profile of Caregivers and Patients (N = 108)**

Characteristic	Caregivers		Patients
<b>Demographics</b>			
Age	Mean	58.0 years	71.8 years
	SD (Range)	12.6 (26-83)	7.3 (52-97)
Sex	Female	92.6% (100)	0.9% (1)
	Male	7.4 (8)	99.1 (107)
Married	Yes	90.7% (98)	—
	No	9.3 (10)	—
Race	White	77.8% (84)	77.8% (84)
	Nonwhite	22.2 (24)	22.2 (24)
Residence	City	46.3% (50)	—
	Suburb	17.6 (19)	—
	Rural	36.1 (39)	—
Income Above \$15,000 <sup>a</sup>	Yes	42.9% (45)	—
	No	57.1 (60)	—
Education	Mean	10.8 years	—
	SD (Range)	3.2 (2-20)	—
Relationship to patient	Spouse	68.5% (74)	—
	Child	21.3 (23)	—
	Other	10.2 (11)	—
Lives With Patient	Yes	76.9% (83)	—
	No	23.1 (25)	—
Caregiving Duration	Mean	105.4 months	—
	SD (Range)	120.2 (1-576)	—
<b>Health Status and Service Use</b>			
# of Medical Problems	Mean	—	3.3
	SD (Range)	—	1.6 (1-9)
Duration of Illness	Mean	—	142.4 months
	SD (Range)	—	148.6(1-564)
Duration of clinic use	Mean	—	28.7 months
	SD (Range)	—	38.5 (0-216)
Clinic visits <sup>b</sup>	Mean	—	13.6
	SD (Range)	—	18.5(1-98)
Functional capacity: daily living activities done without help <sup>c</sup>	Mean	—	4.9
	SD (Range)	—	3.8 (0-13)

<sup>a</sup> No response on 3 cases    <sup>b</sup> No response on 15 cases

<sup>c</sup> Includes items from both the Activities of Daily Living (ADL) and Independent Activities of Daily Living (IADL) scales.

A composite scale and three subscales of caregiver satisfaction with the clinic and its physicians are provided. Questions were scored along a 1-5 Likert continuum (strongly disagree to strongly agree), and items were selected on the basis of face validity, factor analysis, and internal consistency. The subscales were: *satisfaction with information on illness*, *physician affect* (sensitivity of the physician to the feelings, needs, and contributions of the caregiver), and *physician reciprocity* (physician communication style, dominance, and control over interaction). In addition to these scales, three single item indicators assessed general satisfaction with medical services, social support services, and overall care. For all scales, negative items were reverse coded so that high scores represented higher levels of satisfaction. Scale statistics are presented in Table 2.

**Table 2**  
Description of Caregiver Satisfaction Scales and Indicators

Variable	Scale Range	Scale Mean	Scale SD	Per		
				Item Mean	Item-to-scale Correlations	Alpha
<b><u>Communication Sub-Scales:</u></b>						
Information on Illness	3-35	25.9	4.8	3.7	.55 - .75	.88
Physician Reciprocity	17-45	34.2	4.5	3.8	.43 - .73	.83
Physician Affect	8-35	23.9	4.9	3.4	.49 - .72	.86
Overall Communication	43-111	84.2	12.6	3.7	.36 - .76	.93
<b><u>Single Item Satisfaction Indicators:</u></b>						
Overall Medical Services	1-5	4.3	0.7	—	—	—
Overall Support Services	1-5	4.0	0.7	—	—	—
Overall Care	1-5	3.9	0.9	—	—	—
<b><u>Caregiver Knowledge Scales:</u></b>						
Report of Number of Medical Services Provided Patient	0-9	4.5	2.3	0.3	.37 - .62	.80
Report of Number of Social Support Services Provided Patient	0-6	2.0	1.5	0.3	.59 - .73	.87
<b><u>Caregiver Stress:</u></b>						
Caregiver Role Strain	8-35	19.1	5.9	2.7	.57 - .71	.86
Support From Relatives	0-6	2.9	2.4	0.5	.65 - .84	.91

## Results

The per-item means for the three satisfaction with communication scales and their composite fell between 3 and 4 (i.e., neutral to satisfied; Table 2). The information on illness subscale indicated that physicians involved most caregivers in the communication process during medical encounters and were especially good at conveying the nature of the patient's condition and explaining medical tests, treatments, and medications. Caregivers also appeared quite satisfied with the level of reciprocity physicians demonstrated during medical encounters. They were especially agreeable that the doctors appeared knowledgeable, spent enough time with them and the patient, listened to them, looked into their concerns, and did not avoid answering questions. Caregivers also felt free to speak their minds and felt that the doctor made it easy for them to speak. But they were slightly less agreeable that they felt free to talk about personal problems.

The positive affect scale had a per-item mean slightly lower than the other two subscales, with more respondents answering in the neutral range. While the caregivers felt understood by the doctor and agreed that the doctor made them feel that what they had to say was important, they were less agreeable that the physicians encouraged them to express their thoughts on the patients' treatments. Furthermore, for many respondents, the doctors failed to assess how a patient's illness impacted on the caregiver. For example, compared to their focus on the patients' medical states, doctors were less likely to ask caregivers how they were coping with the demands made on them by patients, and some physicians appeared insensitive to caregiver stress. Also, doctors often failed to acknowledge a caregiver's contributions to the patient's care.

In summary, this close look at dimensions of caregiver satisfaction revealed caregivers to be generally satisfied with physician communication as it pertained to the patient's medical encounter and condition. What many caregivers perceived to be lacking, however, was an acknowledgment by the physician that the caregiver undergoes much strain in providing support to their patients outside the clinical setting.

### Accounting for Caregiver Satisfaction with Medical Encounters

To explain the variation in our caregiver satisfaction measures, we used stepwise regression on predictor variables. Zero-order correlations are presented in Table 3. The results of the regressions are presented in Table 4. Two sets of statistically significant variables emerged: (1) those related to

**Table 3**  
Zero-order Correlations (Pearson's  $r$ ): Caregiver Satisfaction Scales,  
Knowledge of Clinic Services, and Caregiver and Patient Personal and Situational Variables

	X1	X2	X3	X4	X5	X6	X7	X8	X9	X10	X11	X12	X13	X14	X15
X <sup>1</sup> Satisfaction with information on illness	1.000														
X <sup>2</sup> Satisfaction with physician control	.679 <sup>c</sup>	1.000													
X <sup>3</sup> Positive affect	.653 <sup>c</sup>	.672 <sup>c</sup>	1.000												
X <sup>4</sup> Satisfaction with communication	.882 <sup>c</sup>	.878 <sup>c</sup>	.885 <sup>c</sup>	1.000											
X <sup>5</sup> Overall satisfaction with medical services	.382 <sup>c</sup>	.414 <sup>c</sup>	.429 <sup>c</sup>	.464 <sup>c</sup>	1.000										
X <sup>6</sup> Overall satisfaction with social support services	.432 <sup>c</sup>	.357 <sup>c</sup>	.396 <sup>c</sup>	.469 <sup>c</sup>	.641 <sup>c</sup>	1.000									
X <sup>7</sup> Satisfaction with overall care	.434 <sup>c</sup>	.512 <sup>c</sup>	.402 <sup>c</sup>	.512 <sup>c</sup>	.388 <sup>c</sup>	.204 <sup>a</sup>	1.000								
X <sup>8</sup> Caregiver report of number of medical services provided patient	.205 <sup>a</sup>	.087	.158	.194 <sup>a</sup>	.060	.237 <sup>b</sup>	-.086	1.000							
X <sup>9</sup> Caregiver report of number of social support services provided patient	.159 <sup>a</sup>	.080	.161 <sup>a</sup>	.181 <sup>a</sup>	.178 <sup>a</sup>	.474 <sup>c</sup>	-.088	.533 <sup>c</sup>	1.000						
X <sup>10</sup> Caregiver role strain	.285 <sup>c</sup>	-.366 <sup>c</sup>	-.252 <sup>b</sup>	-.328 <sup>c</sup>	-.168 <sup>a</sup>	-.121	-.349 <sup>c</sup>	.250 <sup>b</sup>	.271 <sup>b</sup>	1.000					
X <sup>11</sup> Patient functional capacity	.190 <sup>a</sup>	.180	.023	.136	.050	-.074	.232 <sup>b</sup>	-.173 <sup>a</sup>	-.409 <sup>c</sup>	-.407 <sup>c</sup>	1.000				
X <sup>12</sup> Number of medical conditions	.014	.172 <sup>a</sup>	-.049	.045	.154	-.071	.066	-.093	-.032	.07	5.071	1.000			
X <sup>13</sup> Patient age	-.092	.120	.061	-.101	-.178 <sup>a</sup>	.000	-.160 <sup>a</sup>	.258 <sup>b</sup>	.207 <sup>a</sup>	.217 <sup>b</sup>	-.228 <sup>b</sup>	.041	1.000		
X <sup>14</sup> Caregiver education scale	.029	.160 <sup>a</sup>	.016	.078	.113	.029	-.030	.033	.054	.085	.052	.000	-.183 <sup>a</sup>	1.000	
X <sup>15</sup> Support from relatives	.148	.153	.207 <sup>a</sup>	.184 <sup>a</sup>	.004	-.132	.037	-.110	.142	.155	.049	.142	-.035	.001	1.000

<sup>a</sup>p < .05 <sup>b</sup>p < .01 <sup>c</sup>p < .001

**Table 4**  
**Standardized Regression Coefficients for Caregiver Satisfaction Scales Regressed on (a) Caregiver Knowledge of Clinic Services Provided and (b) Caregiver and Patient Personal and Situational Variables**

Independent Variable	Satisfaction with Communication Scales			General Satisfaction Items			
	A Inform- ation on illness	B Physician control	C Positive affect	A+B+C Overall Communi- cation	Overall medical services	Overall support services	Overall care
<b><u>KNOWLEDGE OF CLINIC SERVICES PROVIDED</u></b>							
Caregiver report of number of medical services provided to patient	.232 <sup>b</sup>	.156	.169	.221 <sup>b</sup>	.036	.020	.012
Caregiver report of number of social support services provided to patient	.228 <sup>b</sup>	.173	.185	.246 <sup>b</sup>	.273 <sup>b</sup>	.546 <sup>d</sup>	.060
<b><u>PERSONAL AND SITUATIONAL VARIABLES</u></b>							
Caregiver appraisal of role strain	-.296 <sup>c</sup>	-.415 <sup>d</sup>	-.306 <sup>c</sup>	-.378 <sup>d</sup>	-.217 <sup>b</sup>	-.261 <sup>c</sup>	-.307 <sup>b</sup>
Patient functional capacity	.179 <sup>a</sup>	.097	-.027	.095	.050	.038	.123
Number of medical conditions	.062	.219 <sup>b</sup>	-.033	.089	.197 <sup>b</sup>	-.014	.108
Patient age	-.090	-.060	-.071	-.091	-.180 <sup>a</sup>	-.054	-.091
Caregiver education	.008	.164 <sup>a</sup>	-.015	.068	.080	.009	-.030
Support from relatives scale	.139	.092	.209 <sup>b</sup>	.164 <sup>a</sup>	-.024	-.095	-.026
<b><u>SOURCES OF VARIATION</u></b>							
Knowledge of clinic services	R <sup>2</sup> .045	.009	.033	.046	.034	.225	.004
Personal and situational	R <sup>2</sup> .102	.216	.105	.139	.093	.052	.141
Joint effect	R <sup>2</sup> .085	.057	.044	.088	.034	.029	.006
Total	R <sup>2</sup> .232 <sup>d</sup>	.282 <sup>d</sup>	.182 <sup>b</sup>	.273 <sup>d</sup>	.161 <sup>b</sup>	.306 <sup>d</sup>	.151 <sup>b</sup>

a p < .10 b p < .05 c p < .01 d p < .001

the clinical encounter, measured as a caregiver's knowledge of the clinical services provided the patient, and (2) the personal characteristics of caregiver and patient and the situational variables which impact on the caregiver's role performance and psychological well-being.

On the satisfaction with information on illness scale, caregiver appraisal of role strain was the strongest predictor of satisfaction. Related to caregiver role strain was patient functional capacity, which also influenced satisfaction. In addition, those caregivers with greater knowledge of the medical and social support services provided to the patient were more satisfied.

On the physician reciprocity scale, caregiver appraisal of role strain was again the strongest predictor. Furthermore, the number of patient conditions influenced satisfaction because the more extensive a patient's condition, the greater the opportunity for a caregiver to get involved in the medical aspects of encounters. As long noted in the literature, patients with education levels closer to that of physicians experienced less social distance and seemed better equipped to obtain satisfactory answers to the technical aspects of care that establish physician dominance (Buller and Buller, 1987).

With the positive affect scale, the circumstances of the caregiver seemed to be the important predictors. Caregivers under strain from dealing with their relative's illness were less likely to feel positive toward the physician, while those with greater support from relatives were more likely to feel positive.

The results for the composite scale of overall satisfaction with physician communication paralleled those of its subscales. Caregiver appraisal of role strain was the strongest predictor, with knowledge of medical and social support services and support from relatives explaining additional variation.

For the satisfaction with overall medical services indicator, as one might expect, caregiver's knowledge of these services was strongly related to their satisfaction level. Personal and situational characteristics accounted for additional variation. For the satisfaction with social support services indicator, again caregiver's knowledge of these services was strongly related to their satisfaction. This suggested that an informed caregiver was a satisfied caregiver. Finally, the regression of overall satisfaction with physician care on other variables again revealed caregiving role strain to be an important variable.

At the bottom of Table 4, the amounts of explained variation ( $R^2$ ) in each satisfaction scale are sorted by source, distinguishing clinic-related knowledge variables from personal/situational variables and joint effects, the last reflecting some intercorrelation among the first two sets of variables. The results were striking. For six of the seven measures of satisfaction, personal and situational variables, especially those related to caregiving stress, influenced caregivers'

perceptions of formal care providers more than did the caregivers' knowledge of this formal care. Satisfaction with overall social support services was the only satisfaction measure greatly influenced by actions of clinic personnel, and these services were ones that were less medically related and had a greater influence on what happens to caregivers and patients once they leave the clinic setting.

## Discussion

### Structural Versus Personal Influences on Caregiver Satisfaction

The one outstanding result of the analysis is that personal and situational variables far outweigh clinic-related variables in influencing caregivers' perceptions and attitudes toward physicians and the medical encounter. These findings are important because, while the clinic can control what goes on in the medical encounter itself, the circumstances of the caregiver are less directly influenced by clinic personnel, and may in fact be immutable. Caregiver appraisal of role strain especially stands out. Role strain pertains to what occurs away from the clinics; yet, caregivers' feelings toward the clinics and its physicians are not independent of these external factors. Put another way, what happens to caregivers outside the clinics may greatly influence satisfaction with services inside the clinics. Satisfaction with communication may be more the result of general caregiver well-being than the structure of services.

While the literature fails to provide us with data on caregiver satisfaction with clinical encounters with which to tie our results, it is informative to compare our findings to those of research on patient satisfaction. Specifically, patients who are under more stress and who are more ill tend to be less critical of the care they receive (Buller and Buller, 1987). Conversely, those patients who are healthier and under less stress tend to be more *dissatisfied* with their health care. If previous patient satisfaction findings were comparable to caregivers, one might expect caregivers of less healthy patients to be more satisfied with the care their patients receive. This finding is not supported by the data; a less healthy patient leads to a dissatisfied caregiver, apparently by adding to caregiver role strain. This appears in the negative correlation between satisfaction measures and patient functional capacity, and between functional capacity and caregiver appraisal of role strain (Table 3). Caregiver satisfaction appears distinctive from patient satisfaction.

That patient and caregiver satisfaction are distinct might be related to the complexity of the caregiver role. In terms of role tasks, obligations, and privileges, the caregiver role combines patient *and* provider dimensions. Physicians are likely to interact with caregivers as though the latter were simply extensions of the patient and, thus, bestow sick role obligations on them (Parsons, 1951). For instance, there are unstated assumptions that the caregiver accept the competence of the professional and encourage the patient to seek technically competent help and adhere to medical regimen, even when the patient fails to accept these sick role obligations. At the same time, in some regards the caregiver role is an extension of the physician's. The caregiver is held responsible for providing care tasks to the patient, yet lacks the comprehensive support system that accompanies physicians when they perform a providing role.

The marginal status of caregivers is revealed further by the fact that they lack privileges that characterize the sick role. In fact, there may be an inverse relationship between patient privilege and caregiver privilege. For example, as the patient becomes more ill and gains the privilege of exemption from normal roles, it is at this very time that demands on the caregiver increase. In addition, caregivers certainly lack the privileges that characterize the physician's role. Unlike the physician, the caregiver is not protected from emotional strain by the norm of affective neutrality; thus, the caregiver shares the patient's anxieties. Nor is the caregiver afforded professional dominance; thus, husbands may resist the dominance of their caregiver wives or disregard the caregiving directives of their children. This dilemma of double-edged obligations without consonant privileges is especially detrimental when a caregiver must provide for a patient with low functional capacity. The informality and uncertainty of the caregiver role certainly compounds social psychological strain. The caregiver role is performed outside a structured environment, such as a clinic, and it lacks institutionalized privileges.

As elderly caregiving increases with the aging of the population, one might expect the caregiver role to attain some privileges and take on a structure more conducive to the welfare of both care recipient and caregiver. As it stands now, a clear extrapolation of the obligations and privileges of the caregiver role cannot be derived from the literature. The findings of this study are an initial step in filling that research gap.

This research has policy and practical implications. Medical facilities apparently cannot restrict their activities to the provision of medical services, even where "caring" interaction is stressed. These facilities must make greater efforts to alleviate the external conditions that inhibit beneficial patient prognosis and quality of life. Furthermore, given that family

caregivers are a critical link in the care of the elderly, medical practice must be merged with the caregiver's experience in such a way that the caregiver is recognized as a part of the health care team. Progressive geriatric services must include among their priorities charting the circumstances of the external care environment and assisting caregivers by reducing care strain.

One of the major contributions of these data is the wide range of new research questions they suggest: (1) What do caregivers need to know about the care, treatment, and prognosis of the patient, and who should provide this information? (2) How should services be structured to better accommodate the medical care and informational needs of both elderly patients and their caregivers? (3) What does it mean to the patient when the caregiver is not satisfied? (4) How is the physician-patient relationship affected when a caregiver is involved in any way, and especially when the caregiver is dissatisfied? (5) How important is the physician-caregiver relationship from the point of view of the physician? (6) How do physicians obtain satisfaction while caring for dependent patients? (7) What are the limitations on what a formal care facility can do to enhance caregiver satisfaction when so much depends on things outside the clinic setting?

Since current physician payment systems do not reimburse physician activities like talking, understanding, and socioemotional support, there is a formidable challenge before us. The miscommunication and lack of communication between physicians and patients are well-known and often addressed phenomena. The lack of communication and miscommunication between physicians and caregivers, and patients and caregivers is less often acknowledged or studied.

Whether caregivers are providing primarily instrumental services, such as assistance with activities of daily living, or serving as advocates and providing emotional and/or financial support, when individuals are ill or in crisis, they need the help of others. How physicians, patients, and spouses can be encouraged to confront these difficult issues remains an empirical question. How the formal medical care system can contribute to better informal (i.e., caregiver) care is an immediate practice and policy challenge.

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