



# The role of a companion attending consultations with the patient. A systematic review

Emma Troy<sup>1</sup> · Deepak Doltani<sup>1</sup> · Dominic Harmon<sup>1</sup>

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## Abstract

**Objective** To review the literature pertaining to communication patterns and dynamics of doctor-patient-companion or ‘triadic’ medical encounters as identified in both quantitative and qualitative studies. To consider the role of an attending companion in specialist groups using the context of chronic pain as a group example.

**Methods** Studies were identified via database searches and reference lists. The eligibility of studies and data extracted were cross-checked with inclusion and exclusion criteria.

**Results** Of the 1094 titles identified, 20 studies were included for review. Tables were created for patient settings and study outcomes. Results indicated that companions frequently attended consultations, usually with a relative such as their spouse or adult child and were found to influence communicative processes in the encounter. This influence could either be negative (limiting the exchange of information, particularly relating to sensitive topics) or positive (improvement of self-care management), with study outcomes varying widely. The chronic pain subgroup has not yet been researched in the context of triadic consultations.

**Conclusion** Triadic communication can be advantageous in medical encounters; however, as differences exist depending on the individual medical setting, caution should be asserted in generalising findings.

**Keywords** Attending companion · Consultation dynamics · Patient communication · Triadic model

## Introduction

The processes of communication between the physician and patient during a medical encounter have been well cited in the literature, mainly pertaining to the improvement of health outcomes [1–3, 5] and have led to an appreciation of the communication processes in an encounter by medical educators [4] and physicians alike. More recently, the significance of a third person in the encounter is revealing itself as fascinating and until lately, a relatively unexplored aspect of the communication process. A companion, be it family, spouse, or friend, attending a consultation with a patient alters the dynamics and interplay of doctor-patient communication [6].

Wolff and Roter [7] in their systematic review of triadic medical consultations were limited by analysis of quantitative studies ( $n = 17$ ); furthermore, they excluded the role of a companion in paediatrics, palliative care, and other settings.

Qualitative data can lend insight into an individual’s perspectives, behaviours, beliefs, and cultural attitudes and hence this review has included such studies. Laidsaar-Powell et al. [8] sought to employ a broader review of the triadic literature including the roles and attitudes of each party and looked at the preferences toward triadic decision-making as well as incorporating qualitative studies. However, they did not detail any specific subgroup or largely explore the potential for differences certain population groups and settings might have on the triadic consultation.

The term ‘companion’ is used throughout this review which here is synonymous with a person, most often a family member, who accompanies the individual to the consultation. Importantly, the companion alludes to an *unpaid* carer attending with the patient. This is worth mentioning as a person employed by the patient is likely to have a different role and impact on the encounter, than a family member or close friend [9].

Although a path has been laid in the oncology and cancer pain literature with regard to the triadic model, this cannot be said of the ‘benign chronic pain’, or non-cancerous pain, subgroup. The terms ‘benign chronic pain’ and ‘chronic pain’ will be used interchangeably. The role of family in the lives of those with chronic pain is evidenced heavily in the literature,

✉ Dominic Harmon  
dominicharmon@hotmail.com

<sup>1</sup> Graduate Entry Medical School, University of Limerick, Dooradoyle, Limerick, Ireland

thus exploring a need to consider this group in the context of the triadic encounter is warranted. Other subgroup examples identified in the literature will also be included in the review.

This review aims to examine the role of a companion on the communicative processes in the triadic encounter. The frequency and demographics of accompaniment, the dynamics of the encounter involving patient, companion, and physician factors, as well as incorporating specialist subgroups will be included.

## Methods

### Data sources and inclusion criteria

#### Search strategies

A search of relevant electronic databases such as Biomedical Reference Collection, CINAHL, MEDLINE, Psychology and Behavioral Sciences Collection, SocINDEX, PsycINFO, and SAGE was conducted. Search results were limited to articles published from July 1965 to July 2015. Due to the varied nature of keywords in this field, a list of important search terms was developed (see Table 1 for examples). The returned search results were filtered for irrelevant publications or duplicate articles. Inclusion and exclusion criteria were strictly adhered to with regard to decisions on papers to review. (Table 2) Reference lists of articles that met the inclusion criteria were examined for relevant articles.

#### Data extraction

To be included in this review, studies were required to have been published in an English language journal, depict medical visit interactions between adult patients and healthcare professionals, and include qualitative or quantitative data in relation to patient accompaniment as it relates to any of the following: patient or family companion attributes, visit structure, communication processes, and/or outcomes of care. Studies limited to paediatric patients, to inpatients, emergency, or

**Table 1** Data search terms

Triadic interaction or triad or family or relative or companion or third person or spouse or accompaniment or role of family
<b>AND</b>
Consultation or encounter or medical visit or medical encounter or medical setting or doctor or nurse or health professional
<b>AND</b>
Communication or interaction or dynamics or therapeutic relationship or dyad
<b>AND</b>
Specialist setting or pain clinic or pain or chronic pain or chronic benign pain
<b>NOT</b>
Alzheimer or dementia or cognitive impairment

**Table 2** Inclusion and exclusion criteria

Types of studies:	Quantitative or qualitative studies including: -Surveys -Systematic reviews -Observational <i>Exclusion criteria: Interviews/focus groups, papers published in languages other than English, papers not available in full text, book chapters, and discussion pieces. Studies published outside of July 1965 to July 2015</i>
Types of participants:	Companion attending in the consult/triadic encounter/communication must have included: -Adults patients (> 18 years old) <i>Exclusion: Patients with dementia or cognitive impairment which would decrease their ability to participate in the consultation or young children</i> -Companion (relative, spouse, friend) <i>Exclusion: Paid caregivers</i> -Doctor/nurse <i>Exclusion: Other allied health professionals</i>
Types of settings:	Hospital consultation settings and primary care settings including but not limited to pain clinics, oncology, geriatrics, and paediatrics <i>Exclusion: teleconferencing, online consultations</i>
Types of communication:	All types of patient-physician-companion face-to-face triadic consultation and communication, interaction and dynamics, dyadic encounters in the context of chronic pain <i>Exclusion criteria: tetrad/quadrant or teleconferencing consultations</i>

psychiatry visits were excluded. Included, were studies relating to medical visits in all other settings be it oncology, primary care, older adults, pain, or cardiology clinics. Although the primary interest in this review was to consider the dynamics of adults and their doctor, we did allow studies that described routine medical visits by accompanied patients with nurses in the context of chronic pain. Observational studies that investigated accompanied patients' communication using audio-recorded dialogue from medical consultations were included, as well as surveys and patient-companion-physician report studies. In total, 20 studies were identified for review from 1094 titles: 11 observational studies of audio or videotaped encounters that studied medical visits among accompanied patients and 7 surveys of patients, families, and/or physicians. One meta-analysis and 1 systematic review were also included (Table 2).

## Results

A total of 20 studies were selected for review including 11 of observational studies based on audio or visual recordings, 7 studies were based on questionnaires, and 2 studies were systematic reviews/meta-analysis (Tables 3, 4, and 5).

**Table 3** Role of a companion in the consultation

Study (year)	Outcome(s)	Study sample	Patient sample	Type of data	Type of study
Andrades (2013)	This study signifies a supportive role of companion in a consultation which emphasises the need of consultation models to include the “companion”.	100	Tertiary care hospital outpatient clinic	Questionnaire	Cross-sectional
Cene (2015)	Accompaniment to medical visits is associated with better heart failure self-care maintenance and management, and this effect may be mediated through satisfaction with provider communication	150	Tertiary care hospital outpatient heart failure clinic	Questionnaire	Cross-sectional
Del Piccolo (2014)	Accompanied and non-accompanied patients differed more in socio-demographic than clinical characteristics. Companions sustained the patient and shared information without reducing the level of patient involvement.	70	Tertiary care hospital oncology outpatient clinic	Audiotaped dialogue	Observational
Eggy (2011)	Differences in question asking by Black and White patients suggest that Black patients may receive less information from their oncologists than White patients	109	Tertiary care hospital oncology outpatient clinic	Audio-visual recordings	Observational
Eggy (2013)	Companions and patients showed similar levels of agreement with oncologists about what they discussed during visits.	66	First outpatient visit to a tertiary level cancer care centre	Questionnaire	Cross-sectional
Ellingson (2002)	Specific companion patterns of variability exist including relatively passive companions who performed more active roles with physician, relatively active companions who performed more passive roles with physician, and relatively passive companions who performed more active roles when particular topics were raised.	–	Interdisciplinary geriatric oncology team	Ethnographic field notes and transcripts	Observational
Glasser (2001)	Patients accompanied on medical visits are more likely to be women, have lower incomes, and experience worse physical and mental health status. Advocate and supportive roles are played by informal caregivers of elderly patients.	185	Consultations in one large primary care centre, two small family practices, and one large tertiary care centre geriatrics outpatients department.	Questionnaire	Observational
Greene (1994)	Companion may influence the development of a trusting and effective physician-older patient relationship.	30	Initial visit to tertiary care hospital geriatric outpatient department	Audiotaped dialogue	Observational
Labrecque (1991)	Physicians provide more information when patients are accompanied by family members, or if no family are present, when the patient has a worse performance status. Also physicians’ behaviour was affected by both the presence of a family member, and the patient’s performance status	473	Tertiary care hospital oncology outpatient department	Audiotaped dialogue	Observational
Lidsaar-Powell (2013)	Preliminary strategies for health professionals include (i) encourage/involve companions, (ii) highlight helpful companion behaviours, and (iii) clarify and agree upon role preferences of patient/companions.	–	–	–	Systematic review
Mazer (2014)	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	46	Tertiary care hospital oncology outpatients department	Audiotaped dialogue	Observational
Shields (2005)	Being accompanied by a family member or friend does not result in less attention being paid to patients’ concerns	30	Primary care geriatric consultations and tertiary care hospital geriatric outpatients	Audiotaped dialogue	Observational
Street (2008)	Companions vary greatly in their participation. Physicians facilitate companion participation through the use of partnership-building and supportive communication	84	Tertiary care hospital lung cancer outpatient clinic	Audiotaped dialogue	Observational
Wolff (2011)	Potential practical benefits from more systematic recognition and integration of companions in health care delivery processes	–	–	–	Systematic review

**Table 4** Triadic and dyadic encounters in specialist settings

Study (year)	Outcome(s)	Study sample	Type of patient	Specialist setting	Consultation type	Type of data	Type of study
Block (1980)	Patients who reported that their spouses were relatively solicitous in responding to pain behaviour reported marginally higher levels of pain in the spouse-observing condition than in the neutral-observer condition	20	Chronic pain	Pain management program	Triadic	Audio-visual recordings	Observational
Cene (2015)	Accompaniment to medical visits is associated with better heart failure self-care maintenance and management, and this effect may be mediated through satisfaction with provider communication	150	Heart failure	Tertiary care hospital outpatient clinic	Triadic	Questionnaire	Cross-sectional
(Eide 2011)	More concerns were expressed by patients when a high level of empathic responding was employed and when the patient entered the consultation with a higher level of negative effect.	58	Fibromyalgia	Initial consultations in a tertiary care hospital outpatient pain clinic	Dyadic	Audio-visual recordings	Observational
(Flor 1987)	Spouse reinforcement was associated with high interference of patients' pain with spouses' lives, spouses' positive mood, and spouses' perception of more life control, as well as longer duration of the pain problem.	30	Chronic pain	Tertiary care hospital outpatient pain clinic	Triadic	Questionnaire	Cross-sectional
Jamison (1990)	Perceived support is an important factor in the rehabilitation of chronic pain patients.	508	Chronic pain	Tertiary care hospital outpatient pain program	–	Questionnaire	Cohort study
Kenny (2004)	An implicit dialogue exists between doctors and their patients that appeared to undermine the quality of their interactions, challenged each other's credibility and caused distress to both parties.	42	Patients in chronic pain and pain specialists	Tertiary care hospital outpatient pain clinic	Dyadic	Questionnaire	Cross-sectional
Romano (1995)	Spouse solicitous responses to non-verbal pain behaviours were significant predictors of physical disability in the more depressed patients, and were significant predictors of rate of non-verbal pain behaviour in patients who reported greater pain. Spouse solicitous responses did not predict psychosocial dysfunction or total self-reported pain behaviours.	50	Chronic pain	First time consultations in an outpatient multidisciplinary pain treatment program in a tertiary care hospital.	Triadic	Audio-visual recordings	Observational

### Frequency and demographics of accompaniment

>Thirty-six to 57% of older patients and 15–25% of all adult patients in primary care or outpatient clinics are accompanied [8]. The percentage was significantly higher in the context of patients with heart failure, with 61% reporting accompaniment to some, most, or every visit [10] and in female breast cancer patients at 69% [11]. Patients who were female were more likely to be accompanied by a companion in one study [12] whereas Eggly et al. [13] found no difference in sex, and Cené et al. [9] by contrast, found that more

females than males were 'never' or 'rarely' accompanied to visits. According to the meta-analysis by Wolff and Roter [7], companions attending with the patient were female 79.4%, spouses 54.7%, or adult children 32.2%, relatively few were other relatives, friends, or unpaid carers. More recent studies showed similar trends. Andrades et al. [14] illustrated in a cross-sectional study involving 100 patients, in which approximately 86% of the companions were immediate relatives of the patient. Del Piccolo et al. [11] found that patients were usually accompanied by a close family member, either husband or adult child.

**Table 5** Role of family in chronic pain

Study (year)	Outcome(s)	Study sample	Type of study	Type of data
Flor (1987)	Spouse reinforcement was associated with high interference of patients' pain with spouses' lives, spouses' positive mood, and spouses' perception of more life control, as well as longer duration of the pain problem.	30	Observational	Questionnaire of patients attending a tertiary care hospital outpatient pain clinic
Block (1980)	Patients who reported that their spouses were relatively solicitous in responding to pain behaviour reported marginally higher levels of pain in the spouse-observing condition than in the neutral-observer condition	20	Observational	Audio-visual recordings of Chronic pain consultations in a tertiary care hospital outpatient pain management program
Romano (1995)	Spouse solicitous responses to non-verbal pain behaviours were significant predictors of physical disability in the more depressed patients, and were significant predictors of rate of non-verbal pain behaviour in patients who reported greater pain. Spouse solicitous responses did not predict psychosocial dysfunction or total self-reported pain behaviours.	50	Observational	Audio-visual recordings of first time consultations in an outpatient multidisciplinary pain treatment program in a tertiary care hospital.
Jamison (1990)	Perceived support is an important factor in the rehabilitation of chronic pain patients	508	Cohort study	Tertiary care hospital outpatient pain program

## Dynamics of the triadic encounter

### Duration of encounter

Street and Gordon [15] using transcribed audiotaped recordings established that the length of the consultation did not differ depending on whether a companion was present. Similarly, Shields et al. [16] found no differences in the number of words spoken or speech turns taken in triadic versus dyadic encounters. By contrast, the time the physician spent with a patient in a consultation was longer than those unaccompanied in a paper by Labrecque et al. [17] and the presence of a companion at the first consultation after surgery for breast cancer resulted in more questions being asked during a slightly longer discussion, according to the findings of an Italian study (Del Piccolo et al., 2014).

### Information exchange

In a study by Shields et al. [16] involving 30 patients who were randomly assigned to either accompanied ( $n = 13$ ) or unaccompanied ( $n = 17$ ) groups, it was found that companions group were approximately 43% less likely to raise issues in relation to issues exploring the disease or illness. Overall, however, there were no statistical differences between accompanied and unaccompanied visits on the number of issues that patients raised. By contrast, Greene et al. [9] found that patients raised fewer topics in triads than dyads. With physicians in the triad, a companion did not significantly change the number or types of topics they raised in medical encounter [9]. However, six observational studies included by Wolff

and Roter [7] showed physicians engaged in more biomedical information giving when a companion was present ( $p = 0.01$ ).

### Sensitive information

The presence of third party can limit the exchange of information between the physician and patient [12]. Patients may raise different topics when a companion is present. When a third person is present, a patient may be willing to discuss personal habits that the third person is already aware of, such as smoking or diet, but the patient may be reluctant to disclose more intimate personal habits topics such as alcohol use or sexual concerns [9]. In a study by Ellingson [18], some patients expressed discomfort sharing sensitive information such as information regarding sexuality and depression in front of companions.

### Agreement

Companions and patients showed similar levels of agreement with oncologists about what they discussed during visits. Participants were asked whether or not five topics were discussed (diagnosis, prognosis, metastasis, treatment/treatment goals, and side effects) and, if discussed, what oncologists said. Across the five topics, 73.8% of triads agreed on content. Agreement was highest for diagnosis (98.3%,  $n = 59$ ), followed by prognosis (94.7%,  $n = 9$ ), metastasis (76.0%,  $n = 5$ ), treatment goals (50.0%,  $n = 28$ ), and side effects (50.0%,  $n = 22$ ). (Eggly, 2013) This was the only study examined that considered agreement in the triadic encounter.

## Companion involvement in patient subgroups

### Dyadic and triadic chronic pain encounters

In one study which looked at the types of concerns patients expressed in consultation with a nurse at a pain clinic, more concerns were expressed when nurses exhibited a high level of empathic responding Eide et al., [19]. In a study examining interactions between doctors and their chronic pain patients, Kenny [20] indicated that patient and doctor both expected to function as speakers, not listeners, with the consequence that neither doctor nor patient felt heard by the other. There were no studies in our search which involved a triadic encounter at a pain clinic; however, the influence of family members in the lives of chronic pain patients was examined.

### The role of family in chronic pain

In the context of chronic pain, family influence was found in this review to relate to a number of health-associated outcomes. It has been illustrated by Flor et al. [21] that the responses of family members to chronic pain can either lessen a pain problem or exacerbate it and cultivate it into chronicity. Spouses play a pivotal role in re-enforcing patient pain behaviours and disability [22, 23].

Jamison and Virts [24] carried out a case control study comparing patients with supportive families with patients with a high level of family disharmony and limited social support. They found that chronic pain patients who reported their families as supportive had improved pain outcomes.

## Discussion

The body of literature existing in relation to triadic medical encounters transverses a range of specialist areas. The studies reviewed here provide insight into an array of patient, companion, and physician dynamics that influence the communicative process. Results illustrate that the study of specialist subgroups of patient triadic encounters is varied (oncology, older adults, primary care, heart failure); therefore, one should thread carefully regarding the generalisation of such studies to best benefit future practice.

Cené et al. [10] reported a significantly higher number of accompanied visits in the heart failure group in contrast to a primary care setting with various conditions. Patients who are accompanied tend to be sicker [9, 17]. Laidsaar-Powell et al. [8] reported that companions of cancer patients may be more likely to attend consultations. The studies reviewed showed strong themes of female and familial companion accompaniment across specialist groups, which do suggest a degree of comparison between groups in relation to who attends with the patient. Future study on the demographics of accompaniment is required to further investigate the subtleties of the triadic consultation across a variety of patient subgroups.

One meta-analysis reviewed here concluded that more biomedical information was delivered when a companion was present [7]. Physicians may assume there to be a greater degree of comprehension in the triadic versus dyadic consultation and hence provide more technical information. This suggestion would conflict with literature that cites that physicians underestimate rather than overestimate patients' and companions' perceived understanding in triadic encounters [25]. However, as the study by Eggly [25] did not make a comparison with dyadic consultations, we are unable to denote the degree of perceived understanding by physicians between the two settings.

Implications exist with regard to the nature of the information exchanged in a triadic setting [9, 16]. Laidsaar-Powell et al. [8] state that the informational support provided by the companion is useful, such as the taking of notes, especially during important discussions and treatment decision-making. This may indicate that companions do not raise these topics initially, but rather wait for the patient to raise the issue before participating.

Studies also revealed that a companion attending the consultation can limit the disclosure of certain types of information. However, no study solely focussed on the disclosure of sensitive information or discussed the topic in considerable detail. Brown et al. [26] noted that women with complex problems might be reluctant to raise concerns if disruptive children are present (for example, disclosure about violence or marital discord). This indicates that the 'type' of companion present may have a direct influence on the exchange of sensitive information. Cordella [27] in a qualitative study in which seven companion roles were identified, each exerting a different influence on the encounter, but unfortunately, a central focus on sensitive information exchange was not part of the study. Future studies looking at 'companion factors' that influence the exchange of sensitive information is essential to relay to clinicians, the challenges of obtaining important sensitive patient details in the presence of a particular companion grouping.

A study by Eggly [25] found that companions and patients showed agreement with oncologists about what they discussed during visits when asked to recall information. This demonstrates improved clarity in triadic discussion and perhaps reinforcement of details discussed in the consultation, by the companion. Companions often speak 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 [28].

Cené et al. [10] cross-sectional survey of 150 patients with heart failure is an excellent example of the importance of research on triadic consultations in specialist areas. Those who were accompanied had significantly higher heart failure self-care maintenance and self-care management scores [10]. Reproducing a similar study in the context of chronic pain would augment our understanding of the role of a companion in the pain consultation, with the ultimate aim of improving health outcomes.

Understanding the frequency of attendance, who attends with the patient and the unique interplay of the triadic

encounter in this setting, would allow physicians to engage with patients and their families with augmented knowledge and skill. One study on the dyadic pain encounter highlighted the degree of patient engagement based on the level of empathic responding by the health professional [19]. The sensitivity of patients to the physician's approach to the consult has not yet been explored in a triadic setting.

This review acknowledges the importance of a companion's presence in the medical encounter and has detailed the fundamental aspects of triadic communication. Key areas for future research such as the exchange of sensitive information in lieu of companion roles in the encounter, the bearing of the specific medical setting on consultation duration, and patient-companion-physician dynamics in the context of the chronic pain clinic have been provided by this review. Furthermore, our study mandates a need to focus research on specialised medical triadic encounters.

## Limitations

Studies that did not meet the inclusion criteria could not be commented on such as triadic encounters involving other healthcare professionals, settings, and patients such as paid caregivers or those with reduced memory or cognition. An example of a relevant paper that was excluded due to the criteria for exclusion was by Karnieli-Miller et al. [29] as it dealt only with encounters of Alzheimer's disease in memory-clinic visits. Although a structured review was conducted, it is possible that some eligible studies were not identified for inclusion. As it is not a well-indexed field of research, the variable search terms may have reduced our ability to find all articles. Database searches were limited to English language journals only, of which, a disproportionate number were US studies which may result in cultural biases.

## Conclusion

Despite its limitations, this review establishes that while a literature base does exist for triadic encounters, the studies are scattered across various medical fields. Much has been learned in relation to the role and dynamics of physician-companion-patient interactions from individual studies, yet variance in study design, analysis methods, and participant groups makes cohesion of the data difficult. Key aspects of triadic encounters are evident from the studies reviewed, but less is known about the individual factors at play for specialist subgroup encounters. These authors suggest reproducing studies in focussed settings such as outpatient chronic pain clinics. Acquiring this type of specific information could be practically applied in training and practice for that subgroup.

## Compliance with ethical standards

**Conflict of interest** The authors declare that they have no conflict of interest.

**Ethical approval** All procedures performed were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

**Informed consent** Informed consent was obtained from all individual participants included in the study.

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