The social and health gender differences in patient’s companion in the family medicine consultation

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OBJECTIVES: The purpose of this study is to describe gender differences in patient’s companion, and their characteristics, in family medicine consultations.

METHODS: A descriptive and prospective study in a family medicine office (Toledo, Spain) was carried out. For each patient and companion, the following variables were collected: age, gender, chronic illness, chief complaint, medications taken, social class, request for additional tests, kinship, social status and availability of companion. The bivariate comparisons were performed using the test of Chi squared, the Student t test, and the Mann-Whitney test.

RESULTS: 104 companions to the patient in the family medicine office were obtained. Of these, 65 (62.5%) were female, and 39 (37.5%) male.

In the female companions with regard to the male companions: there were 69% in the group of 40-64 years old vs. 49% (p = 0.02); were wife (34%) vs. husband (56%) (P=0.001); were unskilled workers in the 68% vs. el 43% (p=0.036); were workers in the 44% vs. 24% (p=0.036); had more diseases of the musculoskeletal system (26.2% vs. 5.4% in male companions; p=0.014).

CONCLUSION: There is a gender bias in the patient’s companion: she is a middle-aged woman, wife, with poor health, low social class, housewife or worker, accompanying a middle-class patient, male or student. Implicit stereotypes associating to female gender with providers of health continue to express themselves in accompany the sick in the family medicine office. Support interventions for companions of patients should take gender specific risk factors into account.

Key Words: Companions; Gender differences; Family Practice; Family Members; Caregivers; Visit to Doctor’s Office

A ll over the world women are the predominant providers of informal care for family members with chronic medical conditions or disabilities, including the elderly and adults with mental illnesses. It has been suggested that there are several societal and cultural demands on women to adopt the role of a family-caregiver (1). So, spouses often serve as the primary caregivers to their ill or disabled partners (2).

The domain of health includes the entire range of issues which touch on illness, sickness, disease, wellness, as well as those activities of preventing, diagnosing, healing, caring and curing. Thus, questions about women’s participation in this domain profound and immediate concern to women, and involve roles and selves. Women have domestic activities which sustain, literally and symbolically, the way of life. As the providers of health, women are responsible for securing the domestic conditions necessary for the maintenance of health and for recovery from sickness. Women also serve as mediators of outside services. Their responsibilities with the domestic health service unavoidably bring them into contact with professional health service, among them the family doctor (3).

In practice, a third person (companion) frequently accompanies a patient during medical encounter. There is a high prevalence of the presence of a companion, who is in almost one of every 4 visits served in Family Medicine. Companions of the patients in the medical office are usually family members in near 100% of cases (4-9).

The major results of existing studies suggest that the regular presences of companions of the patients in consultations are often perceived as helpful. Accompaniment to medical visits is associated with better self-care maintenance and management, and this effect may be mediated through satisfaction with provider communication (10). Also, companions provide company, emotional support, and they have a role in mobility and decision making of the patients (11,12). However, their participation often poses challenges (13).

Despite all the above, the reports, reviews or investigations about the gender differences in patient’s companion are rather scarce in our environment. Very little research has examined the influence of the gender in companions who accompany patients on everyday visits to the doctor (5,14,15).

In this context, we present a study whose objectives were to describe gender differences in patient’s companion, and their social and health characteristics, in family medicine consultations.

METHODS

An observational, descriptive, prospective study, which included patients of both sexes over 14 years of a family medicine office which has a quota of 2,000 patients, was carried out. The study was performed within a larger one about patient’s companion already published (8). A random sample was chosen. Comparing retrospectively the percentages obtained from companion’s female (63%) and male (37%), assuming a confidence level of 90%, a power of 80%, and a male / female ratio of 0.5, it would be needed a sample of 67 companions female and 34 companions male (16).

From randomly chosen day for 15 consecutive days, from 26 November 2015 to 18 December 2015, the visited patients were included, and data from the companions with patients were collected. Companion was defined as any person who accompanied the patient in the consulting room or that consult instead the patient. Patients were included only one time. Thus, were excluded the repeated consultations of same patient, including only the first visit. If the patient had two companions only was included the data from the first of them in analysis.

For each patient and companion the following variables were collected: age, sex, chronic disease (defined as “any alteration or deviation from normal that have one or more of the following characteristics: is permanent, leaves residual impairment, is caused by a non-reversible pathologic alteration, it requires special training of the patient for rehabilitation, and/or can be expected to require a long period of control, observation or treatment”) (17), and classified according to International Classification of Diseases (ICD-10) (18), taking medication, collecting the therapeutic drugs group,
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classified according to ATC code or system Anatomic Classification, Therapeutic, Chemical (19), sick leave of the patient, the problems in the family context (based on the genogram, and valued by the same family doctor who performed the genogram at the past time, by viewing the family scheme (the genogram was a schematic model of the structure and processes of a family, included the family structure, life cycle when that family is, the important life events, family resources, and family relational patterns) (20-22), social-occupancy class, according to the Registrar General’s classification of occupations and social status code (23,24), if the analytical or imaging test was requested for the patient, if the patient needs a consultation with the specialist, the companion relationship with the patient, and the social availability of companion in relation to the patient.

A Microsoft Excel® file was built, and the IBM SPSS Statistics for Windows, Version 18.0. Armonk, NY: IBM Corp software was used. Descriptive data, which were expressed by standard measures of central tendency and dispersion, were obtained. The bivariate comparisons were performed using the test of chi-square, with Yates correction when it was pertinent, for the test of means in variables with nonparametric distribution. The informed consent of all patients or their guardians for using of data in research was obtained.

RESULTS

During the 15 days of data collection, a sample of 445 patients was obtained, of whom 104 were companions who accompanied to the patient in the office. 65 (62.5%) were female, and 39 (37.5%) male (Figure 1).

![Study flowchart](Image)

**Figure 1) Study flowchart**

Results of the companions

In the female companions with regard to the male companions: there were 69% in the group of 40-64 years old vs. 49% (p = 0.02); were workers in the 44%, housewife in the 40%, retired in the 49%, and unemployed in the 3% vs. workers 24%, retired 48.6%, and unemployed 18% (p=0.001); were unskilled workers in the 53%, and students in the 16% (vs. 64% y 8% respectively in patients accompanied by male; p=0.036), and they were taking more medications of the musculoskeletal system (26.2% vs. 18.9%) (Table 1).

**TABLE 1 Comparisons of the companion female and companion male**

<table>
<thead>
<tr>
<th>Studied variables</th>
<th>Companion male (n=39)</th>
<th>Companion female (n=65)</th>
<th>Statistical significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years of companions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 40 years: 17.9%</td>
<td>54.54 ± 15.62</td>
<td>50.18 ± 13.35</td>
<td>X2=8.173</td>
</tr>
<tr>
<td>40-64 years: 48.7%</td>
<td>40-64 years: 69.2%</td>
<td></td>
<td>(p=0.02)</td>
</tr>
<tr>
<td>≥ 65 years: 33.3%</td>
<td>≥ 65 years: 10.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The social availability of companion in relation to the patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers: 24.3%</td>
<td>Workers: 44.4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired: 48.6%</td>
<td>Retired: 7.9%</td>
<td>P&lt;0.001 (X2)</td>
<td></td>
</tr>
<tr>
<td>Students: 2.7%</td>
<td>Students: 4.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewife: 5.4%</td>
<td>Housewife: 39.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed: 18.9%</td>
<td>Unemployed: 3.2%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*In Chronic diseases and Medications taken only statistically significant comparisons are shown

Results of the accompanying patients

Regarding patients accompanied by women, the 52% were male (vs. only 21% of patient’s males who were accompanied by male; p=0.003), and they were unskilled workers in the 53%, and students in the 16% (vs. 64% y 8% respectively in patients accompanied by male; p<0.001) (Table 2).

DISCUSSION

It has been reported that visits in which one or more family members...
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We found that the female companions were younger than the male companions (69% in the group of 40-64 years old in female companions vs. 49% in male companions; p = 0.02) (Table 1). This gender gap in care (more caregiving burden among those women in middle age than among those in older age) has been reported (2,13). In our study, were wife (34%), daughters (33%), and mothers (25%) vs. husband (56%), father (23%), and son (18%) (p=0.001), which also broadly coincides with other authors, for whom are the most frequent the mother or wife (6,8).

We also found that female companion of the patient was predominantly worker, and of these, were unskilled workers in the 68% (vs. el 43% in male companion; p=0.036) (Table 1), contrary to published data that women caregivers were less likely to be working (27,28).

Many studies have also found that women and female family caregivers experience greater mental and physical strain, greater caregiver-burden, and higher levels of psychological distress while providing care. However, almost an equal number of studies have not found any differences between men and women on these aspects (1, 25,28). We found that companion female had more diseases of the musculoskeletal system and connective tissue (44% vs. 21% in male companions; p=0.024), and they were taking more medications of the musculoskeletal system (26.2% vs. 5.4% in male companions; p=0.014), but we found no difference in diseases or treatments about mental health (Table 1). Other authors have also noted that women caregivers reported significantly more physically unhealthy days than men, and more physical morbidity (lower physical health scores, poorer physical functioning, and loss of physical strength) (29,30).

The companion assumes the value as intermediary and caregiver. The accompanying person's role most frequently described is of advocate for the accompanying person's role most frequently described is of advocate for the accompanying person’s role most frequently described is of advocate for the accompanying person (3). The care of patients "very fragile", the increasing dependence on their families of elderly patients and/or significant chronic problems, along with the complexity of health services, contributing to the perception that informal caregivers and companions have a role indispensable as "intermediaries between the health system and patient." Therefore, it is desirable to emphasize the need to discuss further about the fragility of patient and their family companions, which are mainly women, who can be supported and trained to participate in decision-making on tasks for the care of the sick, so that meet the needs of the patient, the doctor and family (31).

This gender bias is particularly marked in the field of women health and child health (3) But, we found that patients accompanied by women were in the 52% male (vs. only 21% of patient’s males who were accompanied by male; p=0.003) (Table 2). So, the gender bias is extending beyond the health of women and children. In this context, two more interventions can be suggested (in addition to education): 1) support interventions for
companions of patients should take gender-specific risk factors into account; and 2) this gender bias could be a way to humanize health care. Patients with greater needs are most often come accompanied, which is positive. Those more likely to have a family member present include patients with a low level of health literacy, patients with chronic diseases, older patients, and women (32,33). We find that Patients accompanied by women were more frequently male, with fewer ENT diseases, and took more drugs from the musculoskeletal group than male patients (Table 2), which can be globally interpreted as that there was no clinically significant differences between patients according to the gender of her or his companion.

Limitations of our study and future research

The outcomes of impact of gender on companion of the patient may be mediated by several other variables (in addition to those included in this study, such as patient related factors, socio-demographic variables, and effects of kinship status), as culture and ethnicity, but these have not been considered in our research on gender differences (1).

1) We have not studied possible geographical variations (our data refer only to the study area, and it should be prudent to extrapolate them to other geographical areas, which may imply, among other variables, different socio-economic level, beliefs and customs.

2) We have not studied possible gender differences in patient’s companion about information on the health situation and disease in the patient, prevention of anxiety, building of trust, promotes of family dialogue, or aid to decision.

3) It was not collected the meaning or reason to be present companion.

4) The patients’ perceptions about gender differences of patient’s companion were not collected.

5) The relationships of the gender differences of the patient’s companion with the communication in the consultation have not been studied.

In consequence, future studies could include these topics.

SUMMARY AND CONCLUSION

Patient’s companions are predominantly women, of middle age, wives, mothers and daughters, with poor health, low social class, housewives and workers. Male companions are older, husbands and fathers, with better health than female companions, of middle class, and retirees. Patients accompanied either by women or by men have a similar health status. Patients accompanied by women are males, students, of middle class, vs. patients accompanied by men who are women of low social class. The companion “type” is a middle-aged woman, wife, with poor health, low social class, housewife or worker, who accompanying a patient male or student of middle class.

The presence of companion female of patient, usually family members, with the characteristics described above, creates unique opportunities for supporting interventions for this gender bias, which could have better outcomes for the health of family members (patient outcomes as depression, anxiety, relationship satisfaction, disability, and mortality, and family member outcomes as depression, anxiety, relationship satisfaction, and caregiving burden) (28,34,35) (Box 1). Companion seems to play a secondary role, but it can be the main actor (36). And the gender differences should remind us take into accounts specially the companion female during assistance in it can be the main actor (36).

1) Family doctor should be aware at the companion female of the patient.

2) Should take gender-specific risk factors into account (as poor health and low social class).

3) Should be take arrangements that meet the care recipient’s needs and of the patient’s female companion, who is a family patient member.

4) Should focus on educational interventions with gender differences.

5) Should focus on a wide range of approaches gender-specific to facilitate the participation of companions-caregiver’s female in clinical encounters.

6) Could be a way to humanize health care.

7) Introducing policies tailored to enable female to combine gainful employment with providing care for relatives.

8) Informal female caregivers and patient’s female companions should take an active consumer role and participate in the care decision-making process.

REFERENCES


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