FAMILY CAREGIVERS, P

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Abstract

Family caregivers play a major role in maximig the health and quality of life of more than 30 million individuals with acute and chronic illness. Patients depend on family caregivers for assistance with daily activity managing complex care, navigating the health care system, and communicating wittealth care professionals. Physical, emotional and financial stress may increase **icaeegy**ulnerability to injury and illness. Geographically distant family caregivers and althe professionals in the role of family caregivers may suffer additional burden Shysician recognition of the value of the caregiver role may contribute to a positive caregiving experience and decrease rates of patient hospitalization and stitutionalization. Howeverphysicians may face ethical challenges in partnering with patients and and a caregivers while preserving the primacy of the patient-physician relationship. The Airoan College of Physicians in conjunction with ten other professional societies offetts and guidance to physicians in developing mutually supportive patient-physician-caregiver relationships.

Introduction

Family caregivers in the United States **pide**vcare for about 90 percent of dependent community-dwelling individuals with acute and chronic physical illness, cognitive impairments and mental healtronditions (1-3). Familycaregivers as defined here include relatives, partners; finds and neighbors who assist the activities of daily living and complex health care needs that were the domain of trained hospital personnel (4,5). Approximately 30 – 38 million family caregivers over the age of 18 helped patients manage illnesses and treatment recommendations in 2006 (6). They expedite evaluation and may prevent meal i errors and inefficiencies in our fragmented health care system. In addition, caregivers navigate often overwhelming health insurance system and communicate with multiple headthre professionalsCoping with physical, emotional, spiritual and financial challenges affects caregiver health and quality of life as well as patients' health and quality of life.

Although hospice and palliatives are address the impatient in patients on both patients and families, historically the patient-physicize lationship has focused on the patient and his or her rights and interests with less attention to the patient's experience within the context of his or her family and social redenships. Contemporary bioethics, with its emphasis on patient autonomy and conflicted they has supported his model but is beginning to recognize the need for a fance patient approach. Caregivers require information, access to resources and support by recognizing and addressing caregivers' physical, psychological, spiritual and etimonal needs and acknowling the value of the caregiver role.

Integrated health care models suchthes Advanced Medical Home model directs physicians to "create an integrated, cohepetant for ongoing medicadare in partnership with patients and their families" (7). Physics who adopt this approach are poised to extend the key attributes of this model to patients and their caregivers. However, an expanded patient-physician-caregiver relations may present ethical challenges. The American College of Physicians in conjuinor with ten otherprofessional societies offers the following ethical guidance in hespef fostering mutually supportive patient-physician-caregiver partnerships further research.

Development Process

An initial draft of a statement develoed by the ACP Center for Ethics and Professionalism staff and members of tACP Ethics, Professionalism and Human Rights Committee was discussed subsequent revisions normade through December 2007. The draft underwent internal review the ACP Board of Governors and ACP Councils, followed by external peer review the paper was revised then approved by the ACP Board of Regents in 2008. eTIstatement was endorsed by ten medical professional societies: Society of General

The physician's obligation to espect the patient's decisi-making rights and privacy and provide the caregiver with a dequate information can be allenging. Physicians should give patients a dequate portunity to address confidential matters in private. These private exchanges can be especially ortant for addressing concerns about whether a caregiver is acting in the patient best interests. Private exchanges may include determining whether the patient feelte sand well cared for; eliciting fears or concerns; obtaining the names of other if an caregivers the patient might want the physician to contact; and determining whether the patient requires legal or social services. Patients should be evaluated for physical, emotional or financial abuse apart from the caregiver or family more s. Physicians must be familiar with specific state reporting statutes and the implorest of reporting patient neglect or abuse.

Physician accessibility and excellent **com**unication are fundamental to supporting the patient and family caregiver.

The physician should strive to ensume at the patient, family caregiver and other family members have a common, accurate demistanding of the patient's condition and prognosis.

Caregivers cite access to earl, consistent, understand a buffermation about the patient's medical condition and treatments as threads in most pressing unmet need during ICU hospitalizations (16). Physicia believe they provide far medinformation to6(e)-.6(I735is)]TJ 4 8.

adult patient. Patients generally wait for the physician to initiate advance care planning discussions (22). Physicians must always be sensitive to cultural and family values, and should respect family approaches to decisinaking where applicate (23). Declining health and advanced age mark important portunities to solicit decision-making preferences, discuss health care values with the patient and family and allow all to gain a

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Physicians should recognize that geaghically distant caregivers may face unique challenges.

The number of long distance family caregis/ediefined as those how provide care from more than an hour from the family membiorincreasing (41). Although limited data on this population are available, researcing greests that these caregivers face additional burdens (45). In addition to measures that poport all caregivers (e.g., reassurance that the health care team wants another what is best for the patient; providing clear information on the patient's condition prognosis and care plan; establishing a communication plan for keeping the caregivine formed), the physician should identify When death occurs, the physician should personally communicate with the family caregiver, answer questions, and acknowledgeds and its significance (22). Cultural sensitivity is particularly important 5(4,55). When a patient dies after a long hospitalization or course of illness physician should consider follow-up communication with the caregiver through 20 pe call or condolence (18). This support of the family caregiver may improve bereavement outcomes (18), however, signs of significant depression complicated grief may require a referral for intervention.

When the caregiver is a healthcare professional, the physician should draw appropriate boundaries to ensure that the caregiver is not expected to function in a professional capacity in relation to the patient and that the caregiver receive appropriate support, referrals and services.

Although limited data exist56), anecdotal literature suggests that when the family caregiver is a health professional, caving may bring added ounique pressures and ethical challenges (57-60)Any assumptions regarding level of medical knowledge of the patient's specific condition or technicaldae motional ability to accurately assess treatment options may be problematic. The patient should assist in setting reasonable patient and family expectations re

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Conflict of Interest

Cathy Leffler receives royalties from Spri

- 25. Covinsky KE, Yaffe K. Editorial Dementia, prognosis and the needs of patients and caregivers. Ann Intern Med. 2004;140:573-574.
- Ethics and Human Rights Committee, American College of Physicians. Ethics manual: fifth edition. Ann Intern Med. 2005;142:560-82. Available <u>attp://www.acponline.org/runng_practice/ethics/manualAccessed on</u> November 11, 2009.
- 27. Perkins HS. Controlling Death: The false promise of advance directives. Ann Int Med. 2007;147:51-57.
- Karlawish JH, Quill TE, Meier DE. A consensus-based approach to practicing palliative care for patients who lack decision-making capacity. In Snyder L. and IQu Eds. Physician's Guide to End of Life Care. Philadelphia: American College of Physicians; 2001:19-34.
- 29. Fins JJ, Maltby BS, Friedmann E, et al. Contracts, Covenants and Advance Care Planning: An Empirical Study of the Moral Obligations of Patient and Proxy. J Pain Symptom Manage. 2005;29(1): 55-68.
- 30. Fins JJ, Maltby BS. "Fidelity, Wisdom, and Love: Patients and Proxies in Partnership." New York: Fan Fox and Leslie R. Samuels Foundation. 2003.
- 31. Lang F, Quill T. Making decisions with families at the end of life. Am Fam Physician. 2004;70:719-723.
- 32. Quill TE, Byock IR. Responding to intractable sufferiting: role of terminal sedation and voluntary refusal of food and fluids. Ann Intern Med. 2000;132: 408-414.
- 33. Parks SM, Novielli KD. A practical guide to caring traregivers. Am Fam Physician. 2000; 62(12):2613-22.
- 34. Coleman EA, Parry C, Chalmers S, Min S. The care transitions intervention: results of a randomized controlled trial. Arch Intern Med. 2006;1 66(17):1822-1828.
- 35. Musil CM, Morris DL, Warner CB, Saeid H. Issues in @pivers' stress and providers' support. Research on Aging 2003;25:505-526.
- 36. Mezey M. Nurses and their changinegationship to family caregiversin The Cultures of Caregiving. Conflict and Common Ground among Families, Health Professionals and Policy Makers. Levine C. and Murray TH. Eds. 2004 Baltimore: Then Hopkins University Press.
- 37. Brazil K, Bedard M, Krueger P, Abernathy T, htteld L, Willison K. Service preferences among family caregivers of the terminally ill. J of Palliative Med. 2005;8:69-78.
- 38. Given BA, Given CW, Kozachik S. Family support in advanced cancer. CA Cancer J Clin. 2001;51:213-231.
- Levine C, Murray TH. Conclusion. Building on Common Ground. In The Cultures of Caregiving. Conflict and Common Ground among Families, Health Professionals and Policy Makers. Levine C. and Murray TH. Eds. 2004 Baltimore: The Johns Hopkins University Press.
- 40. Dern A, Heath A. Reaching out to caregivers through physicians. Generations (J. Amer. Soc. On Aging) Winter 2003-2004; 27:84-86.
- 41. National Alliance for Caregiving and AARP. Caregiving in the US. April 2004. Bethesda, MD and Washington, DC. Available a<u>http://www.caregiving.org/data/04finalreport.pd</u>Accessed November 11, 2009.
- 42. Evercare and The National Alliance for Caregiving. Everstudy of caregivers inedline: a close-up look at the health risks of caring for a loved one. September 2006. Minnetonka, Minnesota. Available at: http://www.caregiving.org/da/Caregivers%20in%20Dect#%20Study-FINAL-lowres.pdf Accessed November 11, 2009.
- 43. Schulz R, Beach SR. Caregiving as a risk factom fortality: the caregiver htela effects study. JAMA. 1999;282:2215-2219.
- 44. Belle SH. et al. Enhancing the quality of life of detiaecaregivers from different ethnic or racial groups; a randomized, controlled trial. Ann Intern Med. 2006;145:727-738.
- 45. Benefield LE and Beck C. Reducing the distance iandist-caregiving by technology innovation. Clin Interv Aging(2007); 2(2): 267--272.
- 46. Karlawish J, Quill TE, Meier D for the ACP-ASIME-of-Life Care Consensue and the consensue based approach to providing palliative care to patients whole the cision-making capacity. Ann Intern Med. 1999;130: 835-40.
- 47. American Academy of Hospice and Palliative Medicine. Definition of Palliative Care. Available at http://www.aahpm.org/positions/definition.htmAccessed November 11, 2009.
- 48. United States Department of Health and Humanicas. Centers for Medicare & Medicaid Services. Medicare Hospice Benefits. CMS Publication No. 02154 Revised September 2008. Available at: <u>http://www.medicare.gov/publications/Pubs/pdf/02154.pdf</u>cessed November 11, 2009.
- 49. Bascom PB, Tolle SW. Care of the family when the patient is dying. West J Med. 1995;163:292-296.
- 50. Hebert RS, Dang Q, Sc99.(1)4.77964 -1.8 191.46