Advantages and Challenges: The Experience of Geriatrics Health Care Providers as Family Caregivers

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Purpose of the Study: Very little is known about family caregivers who are also geriatrics health care professionals. This exploratory study examines the dual roles of such professionals, the impact of their geriatrics expertise on the care of family members, and the influence of those caregiver experiences on their clinical practice.

Design and Methods: The research team recruited 16 geriatrics health care professionals who participated in 60- to 90-min individual interviews, based on a semistructured guide. Questions explored participants’ dual experiences as geriatrics professionals and as family caregivers. Interviews were audio recorded, transcribed, and analyzed using qualitative data analysis software. Using a thematic analysis approach, the authors identified recurring themes, coding responses into both major themes and subthemes.

Results: The authors found 3 major themes: (a) dual role advantages and disadvantages, (b) emotional impact of dual roles, and (c) professional impact of family caregiving. Participants reported their own geriatrics expertise provided both advantages and disadvantages in caring for their older family members. Although their expertise introduced a significant emotional intensity to their personal caregiving experiences, those experiences positively influenced their professional insight, empathy, and advocacy for the caregivers of their own patients.

Implications: In addition to the well-known burdens of caregiving, a further set of complex stressors is imposed on geriatrics health care professionals serving as family caregivers. The challenges they face despite their expertise also highlight critical challenges facing all caregivers.

Key Words: Caregiving, Qualitative research methods, Caregiver stress, Social roles
Caregiving of older adults is a major social issue with enormous implications for health care and with an estimated cost of $450 billion in the United States alone (Feinberg, Reinhard, Houser, & Choula, 2011). More than 60 million Americans were family caregivers in 2009. The issues of caregiving are complex and involve hands-on help and supervision, financial management/support, emotional support, medical and legal decision making, and health care. It has been well documented that caregivers suffer emotional distress, stress related to their own family and work responsibilities, health issues, and isolation. Earning potential and income are also affected. The Caregiving in the U.S. survey found that 65% of caregivers in 2009 reported shifting their work schedule or taking time off to provide care. Twelve percent of survey respondents reduced their work hours and 9% gave up work entirely (National Alliance for Caregiving and American Association of Retired Persons, 2009).

There is rich data available about caregivers in the United States and strategies to minimize the physical and emotional burden of caregiving. Less is known, however, about the phenomenon of caregiving when the caregiver is also a health care professional, someone immersed in and knowledgeable about the health care system. Even less is known about the impact of the family caregiving experience on clinical practice and the approach to patients and families facing similar joys and struggles. The experiences of geriatrics health care providers, in theory those best equipped to deal with increasing frailty and end-of-life care, have rarely been described.

There have been several qualitative studies examining the experiences of nurses taking care of family members and the impact upon the nurses’ quality of life. Mills and Aubeeluck (2006) found four themes that emerged from interviews with nurses caring for a relative with a life-threatening illness: quality of life, personal and professional boundaries, disempowerment, and positive aspects of caregiving. They also found nurses had specific needs with regard to their dual caregiving roles. Ward-Griffin, Brown, Vandervoort, & McNair (2005) explored the challenges faced by women from four disciplines (nursing, medicine, social work, and physiotherapy) who provided care both in their professional work and to older family members in their private lives. This study found that these caregivers experienced trouble with blurred boundaries, delegation, and limit-setting, resulting in feelings of isolation, stress, and exhaustion. There also has been literature written by and about physicians acting as family caregivers. These authors speak to how intensely personal the experience is (Fromme, Farber, Babbott, Pickett, & Beasley, 2008; Kane & West, 2005; Kleinman, 2009) and describe the caregiving experience of physicians as fraught with obstacles, such as poor communication and fragmented care, and ethical and moral distress in their dual roles (Chen, Feudtner, Rhodes, & Green, 2001; Ward-Griffin et al., 2005).

It is unknown which strategies, interventions, and supports are needed to help those who are in both the professional role of health care provider and family caregiver. Further, the impact of the family caregiving experience on geriatrics health care providers’ own practices has not been studied. This inquiry was prompted by the authors’ own complex experiences as both geriatrics health care professionals and family caregivers. The purpose of this exploratory project was to describe the range of experiences, feelings, supports, perceived helpful interventions, and impact on family and work when geriatrics health care professionals act as family caregivers.

**Design and Methods**

We conducted an exploratory qualitative study with 16 geriatrics clinicians who had also served as family caregivers. Participants were recruited through announcements at staff meetings and an e-mail flyer distributed to faculty and staff of the Section of Geriatrics at Boston Medical Center, Boston, MA. We asked colleagues to forward the flyer to other potentially interested colleagues. We defined geriatrics health care provider as an adult with professional training and experience in clinical geriatrics. We defined caregiver as an individual providing ongoing care to an older family member in the present or past. Interested participants contacted the researchers and were screened to be sure they met inclusion definitions. Written informed consent was obtained from all participants. The research protocol was approved by the Boston University Medical Campus Institutional Review Board.

Two authors (C. M. W. and H. P. A.) conducted 16 semistructured interviews (eight each) between July and October 2009. Interviews were between 60 and 90 min long and were conducted at locations and times convenient for participants. Interviews were audio recorded and transcribed. Transcripts were identified by code number. Names or identifying information were altered or deleted from the transcribed files to protect confidentiality. The interview guide was designed to elicit information regarding how caregiving began, the personal and emotional impact, experiences of having dual roles, experiences with the health care system, family relationships, and the professional impact of caregiving (Supplementary Appendix A). Analysis of the interviews was conducted using qualitative data analysis software (ResearchWare, Inc., 2009). We used a thematic analysis approach (Crabtree & Miller, 1999) to identify, refine, and name themes. After all the interviews had been transcribed, each interviewer read through all
of the transcripts and developed a running list of codes. The three authors then met to review the preliminary list of codes and used consensus decision making to combine codes that were highly similar in order to develop a more parsimonious code list. Each interviewer read all interviews and analyzed in depth the eight interviews conducted by the other interviewer, utilizing this code list. The authors met to review the results of this coding, examining examples of each code to ensure that both coders were interpreting and applying the codes in the same manner. Coding categories were further grouped and identified as themes based on the second round of analysis, resulting in the final scheme of themes and subthemes reported here. Pseudonyms have been assigned when respondents have been quoted.

Results

Sixteen geriatrics health care professionals participated, including 12 nurses, 3 physicians, and 1 social worker (Table 1). All were white, English-speaking, and the majority women and married. Participants entered the role of caregiver because of their own specific position in their families: they were the only child or only daughter and their role was determined by default, they were the one child without children, they worked part-time, or it was perceived that they had more time to devote to their older family member or due to geography. Most participants had more than one of these factors. Caregivers’ experiences spanned a spectrum: from providing significant hands-on personal care to providing important guidance to other primary caregivers. The role of caregiver either had evolved slowly or occurred due to an acute illness, with end-of-life issues common.

Family dynamics, life experiences, coping styles, and the expertise/skill set of being a geriatrics health care provider shaped the caregiving experience. Each participant had his/her own unique story, but common experiences and feelings were present across participants. Three major themes were identified: (a) dual role advantages and disadvantages, (b) emotional impact of dual roles, and (c) professional impact of family caregiving. Several subthemes were found within these major themes (see Table 2).

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<tr>
<th>Table 1. Caregiver Demographics (N = 16)</th>
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<td>Profession</td>
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Dual Roles Advantages and Disadvantages

Among all the participants, the role of caregiver developed from family needs and was influenced by being a geriatrics health care professional. Some participants assumed the role because it was easier to do the work of caregiving than to delegate. Some were perceived as the most reliable family member. All participants were highly devoted to their older family members. These factors are common among all caregivers regardless of professional training but seemed heightened by the health care backgrounds of these respondents. Participants viewed caregiving as a responsibility assumed because of their professional expertise; it was a pragmatic matter—they had the skills and used those skills automatically. One participant explained as below:

<table>
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<th>Table 2. Major Themes and Subthemes</th>
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<tr>
<td>1. Dual role advantages and disadvantages</td>
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<td>B. Challenges and conflicts from professional expertise</td>
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<td>2. Emotional impact of dual roles</td>
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<tr>
<td>A. Always on call</td>
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<tr>
<td>B. Deliberate stoicism</td>
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<td>C. Recognition as the child</td>
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<td>D. Burden of knowing</td>
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<td>3. Professional impact of family caregiving</td>
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<tr>
<td>A. Insight and empathy</td>
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<td>B. Lessons learned</td>
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<td>C. Advocating for the right care</td>
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<td>D. Focusing on the caregiver</td>
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I don’t know that we ever had a lengthy conversation about it. It was the way she turned to me for medical things, the way she turned to my brother, who is a computer programmer, when her computer went on the fritz, or my sister, who is an attorney, when she needed something else taken care of. She has children in multiple professions, and she just uses them… –Taylor

Many participants described experiences in which their families recognized their expertise and relied upon their knowledge and skills. Families expected these caregivers to know what to do, even if the caregivers did not necessarily feel it was justified:

I think it was just perceived competence. You know, “[She’s] the nurse, [She] deals with old people... [She] will know what to do...” –Robin

Because the expertise of geriatrics health care providers spans a wide range of knowledge and skills including understanding of primary care, community resources, and end-of-life issues, participants used their expertise on an ongoing basis. They viewed use of geriatrics and general health professional knowledge and experience as important tools to help them fulfill their role as family caregiver. Participants described the dual roles of being both a family caregiver and a health care provider as inevitable and all encompassing. Participants did not feel it was easily possible to separate these roles. One participant described the complexity of the role overlap:

She says, “Talk to me like you would talk to your patients...” But of course I can’t, because I’m a family member who’s also a doctor... You want to be able to delegate this stuff to somebody who trusts, and as good of a doctor and caregiver and - medical caregiver and coordinator as you are. That’s the ideal world. I do not want to be her doctor. I do not want to be her case manager. I want to be able to be her daughter, and I hate being in the dual role. –Fran

These caregivers, by nature of having dual identities as family caregivers and geriatrics health care providers, had many and complex roles. These roles often created external and internal conflicts and a range of emotional struggles. Another respondent summarized the phenomenon well:

...In some ways you’re at an advantage, in some ways you’re at a disadvantage. You’re at an advantage because you deal with these issues professionally. But of course you deal professionally from a more detached perspective, because you’re in an objective, professional role. You’re not emotionally enmeshed in the situation. When it’s your own family member of course, you become emotionally enmeshed in the situation. Yet sometimes there’s comfort in ignorance. And as a geriatric care professional, you know what’s going on behind the scenes.

You know perhaps what should be happening and is not happening. –Alexis

Participants expressed both advantages and disadvantages to possessing geriatric health care knowledge through their caregiving experiences. These advantages, challenges, and conflicts of professional expertise were categorized into subthemes.

Benefits of Professional Expertise

Participants described their health care expertise as a huge advantage in caring for older family members. All participants used their skills and knowledge as geriatrics health care providers to aid in their caregiving role. These skills included accessing medical knowledge of relevant health problems, providing personal care, navigating the health care system to locate suitable providers, home services, rehabilitation or long-term care facilities, initiating discussions on advance directives, recognizing illness trajectory, and advocating for the best care possible for their family members. Participants reported using both general medical knowledge and specific geriatrics knowledge, for example, related to minimizing functional decline, mitigating risks for delirium in the hospital, and advocating for appropriate end-of-life care. It was helpful to be able to speak the same language as care providers and use professional connections to gain expert help. Knowing how to access and navigate the health care system was felt to be critical to providing good care.

I had constant contact with the nurse, with the evaluation, with the physical therapy evaluation. But, again, being an insider, I had that much more advantage than the regular person on the outside. And that makes a very big difference. –Chris

Participants described a very intense sense of personal duty and high standards to provide optimal care for their family members. It was a matter of pride, compassion, and pragmatics to use their expertise in caregiving. They expressed the need to feel that they had done their best and had no regrets. They often described feeling they could better recognize their older relatives’ needs or provide the level of caregiving necessary compared with other family members. For these reasons, they felt they were better equipped and prepared to take care of their older family members.

I just feel like I have to do it because nobody is going to do it as well as I’m going to do it. So I have to do it. –Sam

But I felt like I really mattered... I recognized when she was struggling, we went through all the machinations to get her to accept assisted living. She did much better there for several years... So I feel like I did a real good job there and I really had no regrets. And that’s
Participants described different perspectives disclosing or not disclosing their identities as health care providers. Some chose to step back, others wanted providers to know their professional backgrounds, so that they could hear information at a higher level. Some participants chose not to reveal their health care background unless it was necessary because they perceived it would make the providers self-conscious or nervous. Nuanced decisions of when or when not to voice concerns or make suggestions about therapies or plans varied by participant and situation.

I often didn’t start by telling them I was a geriatrician, but by the way I spoke, they knew I was in medicine. Sometimes I’d pull the geriatrician card...I never approached it as a know it all. I approached it as a collaborative partner. As someone who...has worked with other people and knows what works, and who practices this in my own practice, and knows as a family member that this is very important. --Fran

Participants’ professional experiences impacted their ability to intervene in ways other nonprofessional caregivers might not have been able to do so. And though the impact of their interventions was usually positive, respondents described internal angst over their use of health care knowledge. This is closely related to a second major theme, the emotional impact of dual roles.

Emotional Impact of Dual Roles

All participants described multiple ways in which the child/health professional dual role caregiving experience affected them emotionally. Participants often described mixed emotions that illustrated the impact of dual roles. Caregivers gladly provided care and felt a strong sense of reward, but there was a significant theme of emotional struggle:

...everything from extreme gratitude at being able to do it. Having the background and professional experience that makes some things easier is a relief. To anger and frustration at the system. Confidence that you can manipulate it. Grief. The difference between raising your children and launching them is being able to look forward to their maturing and miss them when they’re gone. But when your parents are in decline, there’s no way for it to end well. You know, you’ve seen enough of other people in the next stage that, you know, you know what’s coming...you know that you’re going to lose them. --Taylor

The participants experienced emotions common to all caregivers of any background: emotional exhaustion, guilt, and stress from struggling with multitasking to provide and coordinate care.
So I think at the end of her life, I knew she had a tough life. So I wanted to do what I could for her. But at times, I was stressed with that, and then I’d feel guilty because I was stressed...Well I felt guilty because sometimes I wouldn’t want to be there for her. I was overwhelmed with it. I felt guilty because I didn’t want to do something one day... and then I felt bad after that... –Tracy

Along with the many emotions common to all caregivers, the participants also experienced emotions that seemed specific to being a geriatrics health care provider. Multiple subthemes were expressed, including always being on call, deliberate stoicism, recognition as the child, and the burden of knowing.

**Always on Call**

Nearly all participants described the feeling of never being off duty, because their day job extended into their personal lives as caregivers.

>Just unrelenting responsibility. Crushing. You know, always on call...Sort of low grade anxiety, not in the sense of not knowing what to do, but just waiting for the next shoe to drop. –Robin

... I found myself getting really angry at my mother, because I’d be exhausted... and I would see that she was in failure. And why she didn’t call her doctor. And she said, “I wanted to wait for you.” ...And I finally was able to say, “Mom, it’s not fair to me that you wait until I come up. I do this for a living. I need a break!” [and she said], “Oh, I guess you’re right.” And one time she said, “It’s just because I’m scared, and Dad isn’t here anymore. And you’re the safest person that I have.”

–Marion

These descriptions illustrate how profoundly participants felt the burden of responsibility, anticipation of problems, and weight of continuous stress.

**Deliberate Stoicism**

Many participants discussed holding back emotions as something that they had to do for the good of their families. This approach was described as necessary and pragmatic.

>And we didn’t do this work-up with this questionable nodule, because we weren’t going to treat it...But then, when the actual thing happens when she’s in the hospital, and when she was not doing so well--Well, you know, what are we doing? You know, [my family was] so nervous and having to bring them back to reality. That’s very hard, because I’m feeling it myself, but trying to be very stoic and trying to hold down the fort. That’s hard, very hard. –Sam

Disconnecting from one’s emotions was described as being almost automatic and something caregivers learned to do in their professional lives because it was necessary. Some caregivers felt more comfortable than others stepping in and out of roles.

>It’s not necessarily a feeling, but more just somebody’s got to do it, so I got to do it. So it’s not really an emotion thing, but more of just an intellectual so now you actually step out of the caregiver but into the provider role and you do these things ... as a provider. –Vern

Remaining stoic and professional in the face of a loved one’s illness was very difficult for many. Stepping into the role of child was not necessarily viewed as easy. To be treated as both child and knowledgeable professional was something many participants wanted and needed.

**Recognition as the Child**

Caregivers spoke gratefully about providers who understood the internal conflicts of living dual identities and how emotionally difficult it was to be the child and a health care provider for their family member. Providers who met their high expectations and understood their unique stressors gave them a sense of relief. Being able to trust their parents’ care providers and having these care providers understand their own emotional turmoil greatly eased their stress. Being cared for and having feelings and opinions validated was very important to them emotionally.

>It was this incredible cathartic for me when the right nurse came and could see, and started getting my family to communicate. And that she was my mother’s professional, not me... I had to learn to let her be the expert. When I realized that she was my mother’s nurse...She had great skills. And then I realized that she had the foresight to tell me that, “you’re the daughter.” –Marion

This respondent felt that having a nurse who understood her specific caregiving circumstances gave her permission to be the daughter and not her mother’s nurse.

**Burden of Knowing**

Even with having the right provider caring for one’s family member, participants described the emotional burden of knowing too much. The knowledge and experience professionals bring to the role of caregiver can mean having a different understanding about prognosis and expectations for recovery than other family members. Though all participants recounted innumerable advantages to having a health care background, many described experiences that revealed the burden of knowing too much. Participants discussed feeling emotionally separate from family because of their understanding of prognosis. Because of their clinical backgrounds, they often anticipated and recognized problems before family members. This caused multiple emotions
including isolation, anxiety, and frustration. Participants described feelings of estrangement from other family members because they were perceived as being overly negative and overreacting.

And I just feel like it’s a struggle every time, kind of like I’m talking a different language, almost. They do eventually come around, but there’s several months of, “I don’t know what you’re talking about, I don’t see that with Mom. I think you’re overreacting...” And then finally three months later, “Oh yeah, I think I finally see what you’re saying.” And just those three months, you feel a little estranged from people, and then you kind of come back in and that gets fatigueing after a while... –Aubrey

Participants sometimes experienced rejection or resistance from family members when they tried to provide help. Participants described feelings of frustration when they were not allowed to contribute their expertise.

I would say that it was stressful because of the resistance... Maybe I was considered threatening in some way... But, whether it was the fact that I knew what I knew, whether that was a threat, that’s where the resistance came from, but that was the hardest thing, is not being heard, not being heard— or at least considered... the frustration and the disappointment. And there was anger, because it was like I was banging my head against a wall. And all I was really trying to do was to say “You know, these are the things we might need to put together. And these are the things that we can share, so that we all can pitch in and help, and all feel as though we’re part of the process.” –Charlie

Participants often described feelings of inadequacy when they did not live up to their own or their family’s expectations. Respondents felt family members often assumed they should know everything. They described situations in which they were expected to be the expert but were not, creating feelings of inadequacy, embarrassment, frustration, and anxiety.

He was having what we thought was chest pain, and I said to him, “You need to call 9-1-1,”... And he wouldn’t call 9-1-1 until we got there... he could be having an MI right in front of me and what am I going to do? And again, frustrated that he’s relying on me to take over... I’m not a CCU nurse... So I was scared and I was nervous and I wanted him to take care of what he needed to take care of and not rely on me to be the person to fix it all.... it’s frustrating ...because they think I know everything, and I don’t .... –Dana

Respondents often had conflicted emotions, questioning if they had done the right thing regarding medical issues. Second guessing occurred about whether or not to use their clinical knowledge.

I saw signs in my dad... increased confusion, difficulty breathing, hemoptysis, and everything, you know. But did I bring an oximeter, which I had, to check? No. Nope.... I think to myself this day, did I not do it because I knew what his intentions were and I knew what difference does it make at this age. Or did I not do it because I didn’t want to see it. And that’s a question that I still haven’t answered. –Chris

Participants described the pain they felt in knowing more about what to expect of their parents’ decline and identifying difficult stages and issues to come, including the difficulties managing role reversal.

You’re losing them. And you know you’re losing them. Again, I had to override her, somebody that was very independent. Who did everything despite her disability. And I had to override her. The role reversal. It was very hard.... –Tracy

Participants were very devoted to their older family members and very committed to providing the best care possible for them. Their experiences as caregivers resulted in using what they learned to improve the care of their patients and to reduce caregiver stress. This was the third major theme identified in the analysis.

Professional Impact of Family Caregiving

Participants described many ways in which the caregiving experience enhanced their skills and increased their understanding of patient and caregiver needs. Four major subthemes arose: insight and empathy, lessons learned, advocating for the right care, and focusing on the caregiver.

Insight and Empathy

The caregiving experience gave participants new insights and empathy for patients and families and added respect for what it means to be a caregiver. Participants described many ways in which the caregiving experience taught them how to communicate more effectively and guide discussions about treatment options and advance directives.

...It’s given me tremendous insight. I truly understand at an emotional level what it’s like to care for an elder. The decisions you have to make. What you go through. And because of that, I’m better able to guide people through that process...I think unless you’ve been through an experience of caring for a frail elder, it’s very difficult to really understand the emotions involved, and the stress and anxiety involved, and all the different criteria involved. So I think my ability to guide families
is enormously enhanced by having been through that situation. And I just think I’ve added a great deal to my professionalism...—Alexis

Insight and empathy especially arose over more deeply understanding end-of-life issues. As one participant stated:

And I thought I knew what death was... I had no idea until my father died, what the loss of a parent was. Working for so long in geriatrics...thinking I was doing a good job with my patients and families. Until I lost my dad, I didn’t really get it, what death was like. —Marion

Lessons Learned
Participants described many ways in which their skills were enhanced. Many developed a deeper understanding of hospice principles. Participants used their trial and error caregiving experiences to advise families and share practical hints from their own caregiving experiences. Hands-on knowledge was acquired through humbling experiences:

I was squirting it into my mom’s mouth and finally Dad said, “You know, you have to put it in her, in a well right there.” And I said, “You do?” And it was like, well, I’ve ordered it many times... And yet, I haven’t had to administer morphine... So the physician, you kind of write the script, but you’re not ever administering it. So it was all those pieces that were sort of embarrassing to me that I didn’t know.... I do feel like I have a whole new appreciation of the practical end of caring for someone...I have a whole new understanding. —Morgan

Advocating for the Right Care
Participants discussed many ways in which the caregiving experience helped them to advocate more fully for their patients. They had personally witnessed weak points in the health care system. They felt better able to anticipate problems with transitions of care, including pre- and postoperative care and rehabilitation needs, because of what they experienced as caregivers. They felt better able to identify important services for their patients.

So I think I’m more pushy about people having case management. Families, if they can have it, because it’s the direct care workers and case managers who are probably more important in all of this... It’s direct care workers and their quality and reliability. And the people who direct care across transitions that are, I hate to say it, even more important than any medical care that people get. —Fran

Focusing on the Caregiver
Participants not only felt great empathy for caregivers, but also felt they had a special perspective on caregiving, which they wanted to share. They understood deeply the magnitude of caregiver stress and felt compelled to give their patients’ family caregivers appropriate counseling and support. An important focus described was helping caregivers learn to set limits and try to take care of themselves.

...So it's sort of giving people the guidance of how to set some limits because the individual that needs the help, the patient, doesn't want to lose control but they have to understand what is within their control and what is not within their control. And then some support for the caregivers in terms of how to set limits with them about what they can or can't do and what they're willing to do and what they're not willing to do...I think that's what the caregivers could benefit from, learning to say no when they have to.... —Dana

Focusing on caregivers included reaching out to colleagues in need. Many participants described providing or benefiting from collegial support and wanting to reciprocate in turn. They described how invaluable it was for them to get support from colleagues which helped them to recognize family dynamics and validate their experiences in a safe place. Participants wanted to be a guide and sounding board for colleagues.

The other impact is I think I'm a better support to my colleagues, because it seems like there's a lot of us the same age, going through the same things. I think I do a better job with my colleagues who are going through things...Or noticing and anticipating that they're going to need assistance, even though they don't know it. —Marion

The experiences of family caregiving appeared to have a significant impact on the professional lives of the respondents. These experiences, though often difficult, contributed to how the participants treated and communicated with patients and their families and how they reached out to colleagues facing similar challenges.

Discussion
The analysis identified three major themes: (a) dual role advantages and disadvantages, (b) emotional impact of dual roles, and (c) professional impact of family caregiving. All included both positive and negative feelings. Common emotions identified included: unrelenting responsibility, constant stress, deliberate stoicism, isolation, grief, frustration, feelings of inadequacy, anger and guilt and also great joy, pride, gratitude, sense of accomplishment, insight, and a strong sense of personal reward. Participants felt their specialized knowledge created additional stress based on self- and family expectations to ensure positive outcomes by overseeing the care of their family member. These stressors
varied from worry in anticipation of the next bad event to the loneliness of comprehending prognoses before other family members. Nevertheless, all participants reflected on the positive feelings associated with the caregiving experience and would do it again.

Geriatrics health care providers who function as family caregivers undergo a unique, highly emotional experience. It is made more complex by an in-depth knowledge of geriatric medicine, nursing, social work and an inside understanding of the health care system. The combined expectations of their own and family expectations to positively affect their family member’s care heightened the stress of the entire experience, consistent with previous findings that provider-caregivers felt an uncomfortably high expectation from family members to be involved in their loved one’s care (Chen et al., 2001; Ward-Griffin et al., 2005). For the majority of participants, this led to feelings of isolation as well as the need to always “be on” and have all of the answers. Relaxation was perceived as limited or not possible at all.

Simultaneously, participants felt pride and satisfaction when their geriatrics expertise improved outcomes in the care of their older family members. Caregivers from all professions acted as highly informed advocates for their family members. Feelings of anger were elicited by perceived poor communication and care not meeting their high standards. Anger was also expressed when there was insensitivity to geriatric principles on the part of the provider(s) delivering the care.

The impact of personal experiences on participants’ professional practice was also powerful and positive. Most participants reported feeling more empathic and understanding of their patients’ caregivers’ needs and concerns. Participants reported a deeper appreciation of caregiver stress and utilized their own experience as a tool to support and problem solve their patients caregiver issues. Having lived their own family caregiver experiences, participants felt able to better address the emotional and instrumental needs of their patients and caregivers. It alerted them to the importance of discussing end of life earlier (Mori et al., 2013) as well as the need for greater family education.

These findings build upon the small body of knowledge about health care professionals who serve as family caregivers. Consistent with Ward-Griffin coworkers (2005) and Chen coworkers (2001) findings, our study indicates that this phenomenon of dual role challenges may be common across health care disciplines. Our study was limited by a small sample size and mostly nurse participants. Comparing how individuals from nursing and other health professions approach their involvement in the care of older family members, as well as directly comparing geriatrics and non-geriatrics health care professionals, could be a next step.

This study demonstrates that in addition to the well-known stressors faced by lay caregivers, a further set of stressors affect geriatrics health care professionals who are family caregivers. Perhaps along with standard caregiver survival strategies (Riess-Sherwood, Given, & Given, 2002), interventions tailored to address these unique stressors would help alleviate/moderate the wide range and intensity of emotions described in this study.

Potential interventions might include:

1. Developing a support group specific to provider-family caregivers to create a safe place among colleagues for expressing wide-ranging emotions and sharing ways to alleviate stress.
2. Creating a peer sponsorship program where two caregivers living the experience could offer mutual support and understanding. Peers could provide a sounding board for discussing how to balance the need to take charge versus letting family roles predominate (Salmond, 2011; Wilson & Ardoin, 2013).
3. Mobilizing existing caregiver support resources along with resources for health care providers through a speakers’ bureau or website, which would provide ethical guidelines for maintaining boundaries (Mitnick, Leffler, & Hood, 2010) and recommendations on managing dual role caregiving experiences.
4. Developing educational programs for health care providers who care for older family members of geriatrics and other health care professionals to focus on their specific needs.

Given the challenges reported by experienced geriatrics health care professionals, attention must also be focused on the lay caregivers who have more limited experience coping with aging and end of life. All caregivers need support in the use of communication and negotiation skills to effectively engage with providers regarding concerns about care. Both lay and health care professional caregivers would benefit from developing tools and techniques to discuss the many difficult issues and decisions related to increased frailty, dependence, and dignity of risk (Mastel-Smith & Stanley-Hermans, 2012). It is imperative to focus on empowering and teaching all caregivers and providers how best to have these difficult conversations with family members and with each other, given the inevitability of end-of-life issues in caring for older adults.

**Supplementary Material**

Supplementary material can be found at: [http://gerontologist.oxfordjournals.org](http://gerontologist.oxfordjournals.org).
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