JAMA Network Open

Editorial | Geriatrics

What Role Do Medical Professionals Have Supporting Caregivers?

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Each year in the US, family members provide an estimated $600 billion of unpaid caregiving to older adults.[1] These family caregivers help with a range of tasks, including basic activities of daily living (such as eating, bathing, and getting dressed), instrumental activities of daily living (such as preparing meals and housework), and tasks such as medication management and making decisions about health care.[2] Much of this care is love made manifest—at times, a literal shoulder to lean on when in need. This care is also materially important to the health of older adults and has medical implications; when older adults cannot find help for these tasks, they are more likely to have lower self-rated health and higher Medicare expenditures.[3]

Wolff et al[4] share findings that should prompt medical professionals to consider whether they should be more engaged in supporting caregivers with caregiving. They achieve this through an analysis of 2 paired studies—the National Health and Aging Trends Study (NHATS) and the National Study of Caregiving (NSOC)—and a somewhat esoteric scale known as the relational coordination index (RCI), which measures teamwork. The RCI has been used to study teamwork in industries such as aviation, education, and health care to show that better teamwork is associated with better outcomes.[5] The RCI asks respondents to think about their work with others and rate the extent to which the ingredients for working together—shared goals, shared knowledge, mutual respect, and communication—are present. This implementation of the RCI in the NSOC asked family caregivers to consider their teamwork with 3 other groups: (1) medical professionals (physicians, nurses, physician's assistants, or physical therapists), (2) other family caregivers, and (3) paid caregivers when providing care for their care recipient. Wolff et al[4] found that medical professionals are often involved in care (76.4%) but not considered team players to the same extent as other caregivers (RCI, 3.10 vs 4.20 for family caregivers vs 3.80 for paid caregivers).

The authors should be commended for this analysis and their roles designing and developing the NHATS and NSOC. Through tremendous effort and complex survey design, the studies are nationally representative of older adults in the US and their caregivers. This is a snapshot of older adult caregiving in the US in 2023 from the perspective of caregivers. But the findings prompt an important unanswered question: should the RCI for medical professionals be higher? To paraphrase: should medical professionals be better team players on the family caregiving team?

Some may argue no. Although both types of services are considered care, in the US, medical care (hospitalizations, appointments, diagnostics, prescriptions, and treatment) is distinct from long-term or custodial care (nursing home stays, housekeeping, assistance with activities of daily living). US health care policy reinforces this distinction through public Medicare coverage for medical care but not long-term care; public long-term care coverage is available only through Medicaid as a form of social assistance. Barriers to accessing long term-care (complex eligibility requirements, logistic challenges) exist by design. Medical professionals might recognize the importance of caregiving and caregivers,[6] but in the US, they have an ill-defined professional responsibility for how to help, no financial incentive, and little expertise. It is the role of other multidisciplinary care teams (eg, social workers, care coordinators) to help caregivers find resources and establish networks for caregiving. Medical professionals' time is arguably better spent collaborating and coordinating with other medical professionals and insurers—which reflects the most common use of the term *care coordination* in the literature.[7] Medical professionals do not need to have a high RCI with family caregivers, as frequent communication, shared knowledge, and shared problem solving is unnecessary; perhaps a certain amount of detachment is professional.

Others may argue yes, medical professionals should be better team players on the family caregiving team. The distinction between medical care and long-term care is somewhat arbitrary, nonintuitive, and not shared by all countries.[8] Needs for care often arise during an acute medical hospitalization.[9] Medical professionals diagnose and treat illnesses, so they must surely know something about what it is like to live with a debilitating illness and how to manage other aspects of care. Acute hospitalizations can also increase the complexity of caregiving requirements and necessitate training. Given this, many family caregivers unsurprisingly see health care professionals as experts on caregiving and want advice.[10] This is reinforced when family caregivers are asked to find medical professionals to overcome barriers to accessing care. Medical professionals, whether they realize it or not, gatekeep equipment and services that sit at the ambiguous boundary between medical care and long-term care—things such as rehabilitation, home health, determinations of levels of care in institutional settings, and powers of attorney to access bank accounts on behalf of those who can no longer safely manage money themselves. These privileges make medical professionals indispensable to family caregivers; therefore, medical professionals should be more communicative and accessible.

We hope future work leveraging the RCI clarifies which of these stances is associated with better clinical outcomes. For example, future studies could examine if higher RCI with medical professionals is associated with fewer hospitalizations and lower mortality among older adults. With appropriate adjustment for confounders, this would support a causal link between teamwork and clinical outcomes, emphasizing that supporting family caregivers is good medicine. We could therefore determine if this, in turn, improves the health of older adults.

Consideration of confounding is extremely important. In the study by Wolff et al,[4] RCI was higher among family caregivers who reported more distress and receipt of training from medical professionals on medication management, injections, wound care, and other medical tasks. A potential explanation is that medical professionals get involved when stressful medical care is needed but stay on the sidelines when care is mostly custodial.

If future studies do not show that RCI is associated with better clinical outcomes, this could point to a potentially problematic assumption at the center of this work—namely, that medical professionals, as a class of individuals, have any special expertise about caregiving.[11] In the US, we may live in a medicalized culture about aging, frailty, and caring for our elders that the anthropologist Sharon Kaufman eloquently described over 3 decades ago.[12] She wrote:

> The extended family, with its mandate to care and its knowledge about what is right, appropriate, and natural for its old and debilitated members, has vanished as an institution for many groups in American society… The structure of health care delivery and social services… create the facts, the only informational context that patients and families have as a basis for decision-making and coping with frailty.

We may have collectively lost an older wisdom about what it means to care for our elders and wrongly assume medical professionals are the ones who know best, when instead we must think harder about how we can further identify, develop, and elevate caregiving expertise in other groups.

ARTICLE INFORMATION

Published: November 19, 2025. doi:10.1001/jamanetworkopen.2025.44321

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Conflict of Interest Disclosures: None reported.

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