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Lights and shadows of caring for older adults: The invisible companions in hospitals

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Editorial

As nursing researchers and an ethnographer who have explored the care of hospitalized older adults through ethnographic research and clinical experience, we wish to highlight the often-overlooked role of companions during hospitalization.

Companions play an important, albeit often unrecognized, role in the care of hospitalized older adults. Throughout hospitalization, they provide essential forms of support, including clinical assistance, emotional support, and care coordination. They provide the healthcare team with critical information, assist with medication management and basic activities of daily living, and offer continuous monitoring that may help prevent adverse events.

Our fieldwork, conducted as part of a doctoral dissertation using an institutional ethnographic approach, revealed a concerning pattern: companions of older adults in inpatient wards routinely perform tasks that extend far beyond what would conventionally be considered assistance. We observed companions administering enteral feeding through nasogastric tubes, performing airway suctioning, administering oxygen therapy, providing bed baths, and undertaking both preventive and therapeutic pressure injury care. These activities were performed without formal training, structured supervision, or clearly defined boundaries of responsibility. As one of the participating nurses stated:

"Basically, the companion is providing care in the ward... They are simply told that the patient needs to be repositioned on time, that they should be fed at the appropriate time, or that suctioning should be performed whenever secretions accumulate in the patient's mouth."

These observations prompted us to consider Miranda Fricker's concept of hermeneutical injustice, a form of epistemic injustice that refers to the absence of the conceptual and linguistic resources needed to understand and articulate one's lived experience (1). We use this concept to examine the institutional dynamics underlying this phenomenon. From this perspective, what occurs in the clinical setting should be understood neither as an individual deficiency nor as a lack of awareness among nurses. Rather, it is a structural consequence of a care system that relies on companions' labor while failing to recognize them as knowers. The system expects them to participate in care but does not meaningfully include them in decision-making, provide them with adequate education, or recognize their experiential knowledge; indeed, companions may be asked to leave the room even during nursing handovers. Consequently, companions lived experiences and experiential knowledge are either rendered entirely invisible or interpreted as individual problems rather than understood as manifestations of structural deficiencies within the care system. This pattern is not unique to Iran. Research has shown that companions worldwide face substantial physical, emotional, and social challenges (2,3). These challenges are particularly pronounced in low- and middle-income countries, where shortages of healthcare personnel and inadequate infrastructure further intensify the burden placed on family caregivers. A prospective study conducted in Mexico found that the caregiving burden experienced by primary caregivers was independently associated with increased in-hospital mortality among older adults.

In that study, in-hospital mortality was 48.6% among patients whose primary caregivers experienced a mild caregiving burden, compared with 82.6% among those whose caregivers experienced a severe burden (4).

Symptoms of anxiety and depression among family caregivers of hospitalized older adults are associated with two broad categories of factors: patient-related factors, including older age, disease severity, and multimorbidity; and caregiver-related factors, including sleep disturbance, fatigue, general health status, caregiving burden, and the quality of communication with the healthcare team (2). Nevertheless, despite their essential contributions to patient care, companions in hospitals across low- and middle-income countries remain marginalized and have been described as "the unwelcome but tolerated guest" (5), whose participation in care is rarely formally recognized or adequately valued.

The consequences of this invisibility extend beyond the emotional and physical strain experienced by companions. Even when companions express a desire to participate meaningfully in care, they are systematically excluded. One companion in our study captured this paradox: "When someone entrusts you with a responsibility, you feel more valued... even if it is emptying a urine bag. After all, this is someone you love." Yet, rather than being recognized as care partners, companions are treated as visitors in the very rooms where care is provided. During nursing handovers, they are routinely asked to leave the room and are thus effectively barred from hearing information exchanged about their loved one's condition. They are excluded from decision-making and left inadequately prepared to navigate the complexities of discharge and the transition to home.

As Rogkassa and colleagues have argued, overlooking caregivers' knowledge and experiences represents a missed opportunity to gain deeper insight into the quality of care and achieve their meaningful participation in the treatment process (6). Similarly, Tonkikh and colleagues have demonstrated that families, including those not physically present, provide a broad range of support, including assistance with medical and nursing tasks, learning to perform care activities, and mediating information. Nevertheless, this vital role remains insufficiently visible or recognized within healthcare systems (7). Implementing family-centered healthcare without actively engaging all stakeholders, particularly families, is an unattainable goal.

These findings highlight the need to reconsider how companions are understood and supported within hospital settings. To achieve this, health systems should develop explicit policies defining the roles, responsibilities, and rights of companions throughout hospitalization. Such recognition must extend beyond rhetoric and encompass tangible forms of support, including designated spaces, access to information, and meaningful participation in care planning and decision-making. Furthermore, whenever companions are expected to perform clinical tasks, they must receive systematic, competency-based education and ongoing supervision. This is not merely a matter of patient safety; it is also a fundamental issue of justice for individuals who perform the unpaid work on which healthcare systems depend. This is particularly important given evidence that educational interventions for caregivers

can reduce caregiving burden and alleviate symptoms of anxiety and depression (8,9). At the same time, hospitals should be required to assess and address caregiver burden as a standard component of care for hospitalized older adults. This requires routine screening for caregiver strain, the provision of psychosocial support, and assurance that families are genuinely prepared for the transition from hospital to home. Finally, redesigning documentation and communication systems has a critical role to play. Current systems often exclude companions or treat them as an afterthought; instead, mechanisms are needed to actively document their knowledge and concerns, facilitate genuine collaboration, and recognize the invisible work they perform. Companions of hospitalized older adults are neither visitors nor bystanders; they are essential care partners who perform complex and often clinically demanding work that contributes to patient safety and well-being.

Yet, they remain structurally invisible, inadequately supported, and epistemically marginalized. Therefore, as healthcare professionals, researchers, and policymakers, we have both an ethical responsibility and a practical imperative to acknowledge this invisible workforce, listen to their voices, and build systems that recognize, support, and collaborate with them. The quality of care we provide to our growing older population depends, in part, on our willingness to do so.

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Conflicts of Interest

The authors declare no conflict of interest.

Author Contributions

L.J. conceived the idea and contributed to the conceptualization of the Editorial. F.M. prepared the initial draft. AA.V. and A.S. critically reviewed the manuscript and provided comments and suggestions for revision. L.J. and F.M. contributed to subsequent revisions and finalized the manuscript. All authors reviewed and approved the final version of the manuscript.

Use of Artificial Intelligence

Artificial intelligence was used solely to assist with translation from Persian into English and to improve the manuscript's linguistic clarity and readability. It was not used to develop the conceptual content, analyze or interpret the data, or make scientific judgments. The authors reviewed and approved the final manuscript and take full responsibility for its content.

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