In healthcare the words a physician uses have a profound effect on the well being of the patient ... the right words can potentiate a patient, mobilize the will to live, and set the stage for heroic response. The wrong words can produce despair and defeat or impair the usefulness of whatever treatment is prescribed.

This succinct statement by Norman Cousins aptly summarizes why investigators have become interested in and have speculated about the physician-patient relationship. The nature of this relationship and specific styles of communication between doctor and patient have been described extensively in fiction as well as in research reports. Only within the last 3 decades, however, have empirical studies of this communication, both verbal and nonverbal, been conducted. It is not surprising that investigators have turned their attention to study of doctor-patient communication. First, there are many encounters to study; there are approximately 800,000 patient visits to physicians each year. Second, these visits represent a significant proportion of the health care dollar. Physician reimbursement is about 20% of the annual expenditures, which now exceed 1 trillion dollars. Third, in this era of competition for patients and emphasis on health care outcomes, increased efforts to better understand the dynamics of the relationship are being undertaken in order to increase the probability of positive outcomes in terms of patient knowledge, satisfaction, and compliance, as well as clinical improvement. Finally, technologic advances in data collection instruments have permitted capturing details of interaction in what previously had been a fascinating but confidential relationship.
Several investigators [8] have pointed out that a cohort effect, derived from decades of specific life experiences, may account for why older patients tend to be deferential to physicians and more submissive to physician authority. Changes in experiences, attitudes, and cultural values in more recent decades suggest that future cohorts of elderly patients will be less deferential and submissive. There also may be an age effect resulting from changes in hearing, vision, memory and psychomotor reflexes, all of which can affect the quality of communication. A third factor is the issue of unmet expectations resulting from a mismatch between the current biomedical and acute care approach to health services when the major needs of older patients are largely care for long-term, chronic conditions rather than cure of a specific disease entity. [26] [30]

A fourth and major influence on the physician-older patient encounter (shared with pediatrics) is the frequency with which the older patient is accompanied by a third person, usually a spouse or adult child. [28] Adelman et al [1] have estimated that this occurs in approximately 40% of encounters with patients over age 65. The change from the traditional doctor-patient dyad to doctor-patient-other triad has a profound influence on the nature and flow of communication and the formation of coalitions as demonstrated empirically in recent studies. [10] [22]

Although the focus on the doctor-older patient relationship is growing, it remains a small part of the research in the general area. Moreover, within the focus on the older patient, most communication research has been conducted in the outpatient setting and very little on the hospitalized older patient. This is a curious state of affairs because, as Marshall [33] pointed out, older people are hospitalized more often than are younger persons and, despite diagnostic related groups (DRGs), have longer hospital stays. They are also subject to pejorative labels (get out of my emergency room [GOMER], crock, etc.) more often than younger patients. Perhaps most importantly for analyzing communication, Goss [21] has written that "office and clinic care involves visits to the doctor. Hospital and nursing home care, however, involve visits from the doctor." [11] That is, control over who initiates the relationship, its frequency and duration, as well as whether it is continued, shifts from the patient to the doctor when the care site moves from the outpatient to the inpatient setting.

Furthermore, the severity of illness is usually greater in hospitalized patients, and this may affect the patient's ability and interest in communicating. Sicker patients seem less willing to interact and less able to understand and comply with a physician's instructions. Sicker patients also present more interesting cases, thus attracting more residents and medical students, which can add to the older patient's confusion.

Hospitals have special characteristics that are disorienting to patients of any age [9] but seem especially so for older patients. [25] [40] Schedules for bathing, feeding, and medications often are designed to meet organizational needs (efficiency, use of manpower) rather than patients' needs. Similarly, many hospital personnel need access to the patient, but this often contributes to a perceived loss of privacy. The paucity of research on these obvious influences on the physician-hospitalized older patient relationship suggests that this is an area ripe for exploration.

STRUCTURE OF COMMUNICATION IN THE HOSPITAL

The insightful comment by Goss, cited previously, about who controls the doctor-patient encounter in the hospital setting is supported by analysis of medical discourse in the hospital. Fox, [20] for example, analyzed audiotaped conversations between surgeons and patients and observed their interactions in several hospital settings. He found that the surgeons tended to organize their communication around themes of physiologic response, wound status, and rehabilitation. These themes are "surgeon-centered, and are organized to deny patients access to the agenda of these encounters ... [and] these strategies of discourse organization are understood as techniques of power."

Anspach [2] observed interactions between attending physicians and residents and used oral and written case presentations to assess the effects of that form of discourse on patient care. Because residents make case presentations to attendings, who also eventually evaluate the residents for knowledge and skill (among other things), the form of presentation is highly stylized and acts as a vehicle for professional socialization. The form tends to depersonalize the patient by emphasizing physical and biologic parameters and limiting references to psychosocial factors. Furthermore, the use of the passive voice (e.g., omitting the agent, such as "There was no mention of chest pain.") and technical terms is intended...
to give scientific validity to the physician's report and mitigate the patient's report (i.e., "The lab value for SGOT was X" versus "The patient denies drinking.").

The structure of case presentations may facilitate the ritualized transfer of information between resident and attending and help the resident gain approval for his or her performance, but it can have negative consequences for patients. The language of professional discourse often is not understood by patients, and an adequate effort to translate is not always made. Secondly, it permits, if not encourages, physicians to view their hospitalized patients as cases rather than as individuals. Thirdly, it tends to discount the importance of the patient narrative (history) in the reliance on technologic forms of assessment, as if the scientific way of knowing was the only way of knowing anything.\[16\]

Inadequate communication between primary care physicians and consulting specialists can cause problems for patients as well. Epstein\[17\] has reported that communication problems between physicians arise from several sources including lack of time, missing information, and unclear follow-up plans. Consequences for the patient could mean disruption of care, unnecessary testing, incomplete diagnostic workup, and possible iatrogenic problems.

These investigations of communication patterns between doctors and patients and among physicians themselves in the hospital setting seem to make positive outcomes very unlikely. Yet a majority of hospitalized patients, including older patients, benefit from the experience. One reason is that there is more variation in physician styles of communication than is suggested by studies such as the ones described previously. Roter et al\[39\] studied audiotaped communication among 127 physicians and 537 patients. Although these were primary care physicians and the encounters took place in ambulatory care settings, there is some evidence\[5\] that the same general patterns also can occur in the hospital setting. The analysis identified five patterns of communication: (1) narrowly biomedical, (2) expanded biomedical, (3) biopsychosocial, (4) psychosocial, and (5) consumerist. For the physicians, the majority of talk (65%) was classified as narrowly or expanded biomedical, but 20% of the visits included biopsychosocial talk, whereas 7% and 8% of the visits were psychosocial or consumerist, respectively. Biomedically focused interviews were conducted with sicker, older, and low-income patients by younger physicians.

These communication styles are important because they are linked to outcomes. Bertakis et al\[3\] reported that a communication style that emphasized psychosocial aspects of care predicted improvements in a patient's health status and a style that emphasized patient participation predicted higher patient satisfaction. It has also been reported that patient-centered communication, such as the psychosocial approach, is correlated with fewer malpractice claims.\[32\]

Another reason why the potential for bad outcomes of physician-centered communication is mitigated in the hospital is the role played by nurses as information broker. Bourhis et al\[6\] surveyed physicians, nurses, and patients regarding the use of medical language and everyday language in the hospital. Physicians reported that although they use medical language most often, they use everyday language with patients. This perception was not supported by evaluations by nurses, who tended to use both medical and everyday language. All three groups agreed with the patient perception of the nurse as a broker who helps patients understand the medical language of the doctors.

**COMMUNICATION PATTERNS IN THE HOSPITAL**

Blanchard et al\[5\] observed physician behavior with hospitalized oncology patients. The researchers reported that each visit to a patient averaged slightly more than 3.5 minutes and that the length of time was influenced by the severity of the diagnosis. A factor analysis of the frequencies of different categories of conversation revealed that the most common category concerned treatment and treatment plans (23.3% of variance) compared with introductions (16.1% of variance), examination of the patient (10.5% of variance), and psychosocial support (8.8% of the variance). These findings were supported by Ford et al,\[19\] who also reported on observations of communication in an oncology ward. They showed that patient-centered communication was infrequent, the physicians tended to use closed-ended questions, and the frequency of medical discussion was 2.5 times the frequency of psychosocial discussion.

As in other medical care settings, these encounters also were influenced by the presence of family members.\[21\] Physicians tended to give more time and more information when a family member was present or when the patient was in poorer condition. Patient satisfaction and quality of life were not affected by physician behavior. Elderly patients in the hospital seem to be easier to satisfy than younger...
Physicians may overestimate the success of CPR of patients. A secondary analysis of survey data from 2,667 patients showed that older (age 65+) patients were more satisfied, had fewer emotional problems, and were more passive during a hospital stay.[7]

Although hospitalized patients generally seem to prefer a more patient-centered approach from physicians and to have treatment options presented, this does not always predict patient preferences. One study of oncology patients showed that 92% preferred to be given all of the information about their case, but only 69% wanted to participate in therapeutic decisions. One-fourth of patients wanted the physician to make all of the decisions. These patients were mostly older, sicker men.[4]

DOCTOR-PATIENT COMMUNICATION AT THE END OF LIFE

Perhaps at no time are factors influencing doctor-patient communication and its outcomes more critical than in decisions about end-of-life (EOL) care for hospitalized patients (who are disproportionately older persons). Ethical issues arise over patient competency to participate in decision-making, family as a proxy representative, truth-telling, uncertainty about outcomes, and appropriate use of medical resources, to name just a few. These often difficult and emotional situations sometimes are made even more complex by the inability of all parties to the decision-making to assess accurately the attitudes toward death and preferences for continuing treatment or discontinuing treatment and opting for palliative care. Kai et al[28] assessed Japanese physicians’ estimation of the preferences of their dying patients for (1) accurate and complete information about prognosis, (2) where they wished to die (at home or in hospital), and (3) therapeutic strategy (continued treatment or pain control). Physicians correctly estimated their patients preferences in about half of the cases. A majority of patients preferred to be told the truth about their prognoses (80%), to die at home (70%), and to receive pain control only (66%).

A different study, however, indicated that dying patients (at least those with metastatic colon and lung cancer) overestimate their survival ability and this influences their choice for continued treatment over palliative care.[46] A significant proportion of patients who estimated their life expectancy as 6 months or more opted for aggressive therapy, but their actual survival rate was no better than those who opted for palliation.

A particular problem regarding patients’ overestimation of the success of a procedure appears to relate to cardiopulmonary resuscitation (CPR). Potential recipients of CPR consistently indicate that they are most likely to obtain their information about CPR from media, particularly television.[15] Although thorough scientific reviews indicate that on average 15% of CPR recipients survive to leave the hospital,[41] a survey of 94 older male veterans indicated that they believed that 54% survived to hospital discharge.[42] Alarmingly, the apparent survival rate to hospital discharge of patients receiving CPR in 97 episodes of three popular medical television shows was 67%.[15] Physicians may overestimate the success of CPR as well. In the study by Miller et al,[36] physicians estimated that 30% of CPR recipients would survive to discharge.

These kinds of uncertainties, along with hospital regulations and legal implications, can lead to a process of negotiation between physicians and hospital authorities. One outcome is the informal agreement to use limited codes in which life-prolonging procedures such as CPR, intubation, or use of drugs are used but not to the fullest extent. This agreement gives the appearance of complying with regulations and can mollify families that insist on continued treatment for the dying family member. It may, as a consequence, also avoid lawsuits.[37]

These negotiations do not have to result in evasion of regulations or skirting ethical prescriptions. One study examined the actual conversations among physicians and families of dying patients (sometimes with patient participation) to assess how the treatment decision was reached and the nature of the consequences. The research questions were (1) how physicians introduced the need for a decision on withholding or withdrawing treatment, (2) how likely outcomes were presented (equal emphasis, or shaded toward the physicians’ preference), and (3) who made the final decision. The outcome of the decision was also recorded (died, discharged home, or discharged to another institution). The results indicated that the concept of patient’s wishes was a key factor in the negotiation of a consensus on withholding or withdrawing treatment (even when the patient was not a participant). Physicians most often gave unambiguous and clear reasons for making a decision and even-handed descriptions of outcomes. They did shade the therapeutic options at closure to correspond with their own judgement, but not every final decision was consistent with that judgement. All final decisions were consistent with the patient's wishes, including those that ended in death following withdrawal of treatment. No differences in process
The authors have audiotaped 26 major EOL decision-making interactions involving 22 intensive care unit (ICU) patients. In almost all cases, the physicians' intention clearly was to help the patient and families make the best decisions they could; however, the physicians often struggled to achieve their desired ends and frequently made obvious mistakes in their methods of communication (e.g., overuse of sophisticated medical terminology, pushing for a predetermined conclusion, talking too much and exploring too little, and overlooking significant patient and family concerns). In the effort to improve EOL decision-making in ICUs and elsewhere, one author (DKM) developed the following model to “In4RM” (Inform) physicians of the process. This model provides a catchy way for physicians to remember the crucial elements in EOL communication and thereby facilitate appropriate decision making, hopefully to produce optimal decisions that respect both patients' wishes and medical realities.

The authors believe that training with this or a similar model improves EOL discussions and subsequent decisions. In the past several months one author (DKM) has been discussing the model with residents during their medical ICU rotation, and it has been very well received. Conversely, studies have suggested that improving communication, although necessary, may not be sufficient by itself to achieve desired EOL decision-making goals. A more complete solution may require more research and a full total quality management approach.

Despite the enactment of the Patient Self Determination Act, these issues have not disappeared. This act, however, has compelled physicians to accept responsibility for bringing up issues of resuscitation with patients, checking medical records for evidence of advanced directives, and to be sensitive to patients' values and preferences. The key to successful resolution of these issues was, is, and will remain effective communication between doctor and patient.

CONCLUSIONS

Much research documents the relationship between doctor-patient communication and health outcomes in inpatient and outpatient settings for patients in any age group. But specific barriers to effective communication between doctor and patient are unique to older patients or at least exacerbate the problems of effective communication. Some of these barriers are related to the older person as an individual (decreased sensory motor function, culturally-influenced response to illness), and some barriers are derived from the nature of the hospital itself (especially depersonalizing factors that tend to disorient the older patient). Health care providers in hospital settings can learn how to avoid or overcome these barriers in order to communicate effectively with older patients.

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