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Differential Characteristics in Communication and Relationship of the General Practitioner with the Elderly Patient

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Abstract

Doctor-older patient relationship and communication has special nuances and characteristics because there is a greater heterogeneity of patients, a sensory loss, decreased memory, slower processing of information, decreased power and influence over their own lives, and withdrawal from work and separation from family and friends. In this scenario, this article aims to reflect and systematize same of the differential concepts of the relationship and communication with the elderly patient from the point of view of general practitioner: 1. Type of doctor-patient relationship according to the control exercised by the doctor or the elderly patient (Older patients are more likely to accept the doctor's authority); 2. Non-verbal communication (It becomes a greater way of expressing the mood and it plays a greater role compared to verbal expression); 3. Listening (The interview with the elder is a means for him to reconstruct his life); 4. Verbal communication (The doctor-elderly patient interview should be carried out appropriately to the neurocognitive, sensory and affective conditions of the patient); 5. The pathology in the elderly influences doctor-patient communication (multimorbidity, polypharmacy, and the fact that in the elderly, the disease is seen as a structural situation, an intrinsic element of the person, and not a temporary event); 6. Empathy (The older patients need an empathic communication as an essential part of their treatment); 7. The disease with poor prognosis (Telling the truth is always a particularly delicate situation); 8. The doctor-older patient interview should pay special attention to psychosocial factors (the outcomes of health care for older patients depends on the psychosocial needs).

Keywords: Physician-patient communication; General practice; Framework; Physician-patient relations; Elderly; Health outcomes; Vulnerable populations

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Introduction

The doctor-patient relationship is one of the fundamental pillars of general medical care. The transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care [1-4].

We could say that the "good" doctor-patient relationship is a process where an "alliance" is created: a process in which the doctor adapts to the rhythm of the patient and little by little can help him move towards healthier scenarios; that is, detect "what dance the patient dances and like a good dancer, take a step back, another forward, dancing and pacing with the patient. But there is not a single type of "good" or "adequate" doctor-patient relationship; there is not "a single dance that the patient dances" [5].

But it is a complex, multiple and heterogeneous concept that cannot be defined in a unique way. Thus, there are different types of doctor-patient relationship that are appropriate according to their contexts [6].

One of these special contexts that nuance the characteristics of the doctor-patient relationship and communication is the presence of an elderly patient. The communication process can be further complicated by age. Older patients are actually more heterogeneous than younger people. In addition, the normal aging process may involve sensory loss, decreased memory, slower processing of information, decreased power and influence over their own lives, withdrawal from work and separation from family and friends. On the other hand, older patients are more likely to accept medical authority, both in terms of attitudes and behaviour, than younger groups [7,8].

However, psychological phenomena between doctors and their elderly patients are often not included in the investigation [9]. Poor communication with this vulnerable and growing population can undermine your efforts to provide good patient care [7].

Therefore, a quality communication between the doctor and the elderly patient is essential to achieve good results. This has been demonstrated in terms of clinical evolution, patient satisfaction, the appropriate use of health resources, the feeling of well-being and adherence to treatment among others [10].

In this scenario, this article aims to reflect and systematize the differential concepts of the relationship and communication with the elderly patient in general medicine.

Discussion

A series of differential concepts can be systematized for the relationship and communication with the elderly patient in general medicine [Table 1] [7,11].

Type of doctor-patient relationship according to the control exercised by the doctor or the elderly patient

Three models of doctor-patient relationship can be differentiated: 1. "paternalistic"; 2. "consumerist"; And 3. "Mutual". Elderly patients are more likely to accept the doctor's authority, both in terms of attitudes and behaviour, than younger groups. In contrast, younger patients tend to be more demanding. The attitudes of the patient of age towards the doctors can have consequences of behaviour in terms of whether or not the help of a doctor is sought, with respect to compliance and in relation to trust between patient and doctor [6,12].

Non-verbal communication

Among the factors that help the success of good communication with the elderly, is the emphasis on the role of perception and language. Perception in the elderly may be subject to visual and acoustic changes and to compensate for sensory deficits there may be several cognitive strategies. The language in the elderly, although it does not undergo special changes, except that anomie may occur, plays a minor role compared to non-verbal expression, which becomes a greater way of expressing the mood [13]. So, the following factors can be differentiated:

A. Maintain eye contact. Eye contact is one of the most direct and powerful forms of non-verbal communication. It tells patients that you are interested in them and they can trust you. Maintaining eye contact creates a more positive, comfortable atmosphere that may result in patients opening up and providing additional information [7].

B. The relationship between doctor and elderly patient implies special relational and communicational values. William Osler said that "there are two types of doctors: the one who exercises with language, and the one who exercises with the brain." That is to say, the word is not always a modality of consistent and adequate expression for thoughts and feelings. Especially in clinical situations of particular suffering and severity, their modulation, tone, pauses, and silences are instruments of confirmation and opening of a relationship of trust. It does not communicate only with verbal language; communicates each time we approach the patient to provide the appropriate treatment and also in the interviews through our behavioural modalities. The patient, especially in situations of suffering, has a particular sensitivity to the attitude of those who attend to him, and with greater emphasis on non-verbal communication.

C. The careful listening of the expert is one of the irreplaceable therapeutic instruments. You cannot really know the patient if you have not had time to listen to their request for full help. Listening to the sick person inevitably means being heard. It's about being able to reach an informed consensus.

Listening

The most common complaint patients have about their doctors is that they don't listen. Good communication depends on good listening, so be conscious of whether you are really listening to what older patients are telling you. Many of the problems associated with non-compliance can be reduced or eliminated simply by taking time to listen to what the patient has to say [7].

Taking into account the need for a symmetrical colloquium in the clinical interview with the elderly patient, this implies that the doctor is willing to integrate and listen to what the elderly person wants to communicate, including being attentive to non-verbal communication, and calibrate their own language and make feedback of what the patient expressed. The interview with the elder is a means for him to reconstruct his life, where the meaning of the assistance will emerge and perhaps also the factors and conditions that can be identified in the roots of pathology in the context of a clinical picture.

The information obtained from the relationship of the attending doctor with elderly patient provides the best possible way to eliminate or minimize many ethical conflicts that arise in the care of elderly people. The General Practitioner (GP) can seek information about the personal value scheme and the patient's expectations and use these data to better care for the patient [14].

The doctor-elderly patient relationship does not refer mainly to a contact between sick and professional to restore the health of the former, but of a contact with a specific or particular patient, with a life experience. The GP should ask about his teeth, family environment, diet and emotions; it is not about requesting more tests or drugs. The main drug is the doctor himself, his affection [15].

Verbal communication

It should be allowed extra time in the consultation for older patients. Studies have shown that older patients receive less information from physicians than younger patients do, when, in fact, they desire or need more information from their physicians. Because of their increased need for information and their likelihood to communicate poorly, older patients are going to require additional time. GP should sit face to face and avoid distractions because of some older patients have vision and hearing loss, and reading your lips may be crucial for them to receive the information correctly [7].

The doctor-elderly patient interview should be carried out appropriately to the neurocognitive, sensory and affective conditions of the patient. This means taking into account:

A. Brief instructions: GP have to use short, simple words and sentences. Simplifying information and speaking in a way that can be easily understood is one of the best to ensure that older patients will follow the instructions. GP should not use medical jargon or technical terms that are difficult for the layperson to understand. In addition, patients will understand even basic medical terminology. Instead use technical words, the GP make should sure to use familiar words and to achieve a comfortable relationship with patients.

Table 1: Differential concepts for the relationship and communication with the elderly patient in general medicine.

Differential concepts for the relationship and communication with the elderly patient in general medicine	
1	Type of doctor-patient relationship according to the control exercised by the doctor or the elderly patient
2	Non-verbal communication
3	Listening
4	Verbal communication
5	The pathology of the elderly influences communication
6	Empathy
7	The ill-fated disease
8	The doctor-older patient interview should pay special attention to psychosocial factors

B. GP should simplify and write down the instructions. When the GP gives instructions to the patients, they should avoid that they are complicated so as not to confuse the patient. Instead, write down your instructions in a basic, easy-to-follow format. Writing is a more permanent form of communication than speaking and provides the opportunity for the patient to later review what you have said in a less stressful environment.

C. GP should stick to one topic at a time: Information overload can confuse patients. To avoid this, instead of providing a long, detailed explanation to a patient, try the information in outline form. This can allow explaining important information in a series of steps.

D. GP has to speak loudly, looking at the patient's eyes, slowly; speaking slowly, clearly and loudly. The rate at which an older person learns is often much slower than that of a younger person. Therefore, the rate at which the GP provide information can greatly affect how older patients can take in and learning. The GP should not rush through the instructions to these patients. The GP should speak clearly and loudly enough for them to hear you, but without shouting [7].

E. GP should wait long enough for each answer and for older patient to ask questions: Give patients an opportunity to answer and to ask questions and express themselves. Once you have explained the treatment and provided all the necessary information, give older patients ample opportunity to ask questions.

F. GP must corroborate the data with the relative or caregiver or companion: allow them to express any apprehensions they might have, and through their questions, the GP will be able to determine if they completely understand the information and instructions he has given.

In the care of the elderly, family or caregivers play an essential role, especially in those with some degree of dependency. It is necessary to count on your collaboration to carry out an adequate clinical history and its implication in the fulfilment of the treatment is paramount [10].

The pathology of the elderly influences doctor-patient communication

On the one hand in the elderly there is often multimorbidity: osteoarthritis, arterial hypertension, cardiovascular disease, depression, COPD, loss of visual and auditory capacity, falls and immobility, osteoporosis, dementia, delirium, urinary incontinence, etc., and 20% of them are patients with disabilities.

Multimorbidity implies polypharmacy, with an average of 4.5 drugs prescribed by the doctor to the older patient. In addition, with aging increases the risk of developing CNS disorders. There may be a cerebral deficit associated with psychological symptoms that reflects psychiatric disturbances. In addition, the elderly may present with Alzheimer's disease, vascular dementia, alcoholic dementia, brain neoplasia, or crania-encephalic trauma, all of which have serious implications for doctor-patient communication.

In clinical general practice, the presence of multimorbidity when there is a disease that seems to be a dominant one or a priority, and so it attracts all GP care, for example dementia, involves the risk of not paying attention to other symptoms that the elder wants to communicate to GP in relation to other diseases [16].

The old people lives his illness feeling very exposed to complications and eventualities due to his fragility, with small adjustment and anguish. For the elderly, the pain is closely linked to the sense of illness and their suffering is experienced as the direct consequence of this. The old man expresses less the fear of death as suffering. The disease can emotionally destabilize to the elderly. For the elderly to be ill accentuates their perception of being a burden for others and this increase the awareness of not being able to adapt to their tasks. In addition, the disease induces a greater degree of depression, weakness, dissatisfaction, fear and anguish to death. The old man identifies the disease with feeling useless. While in young ages the disease is considered a temporary event, in the elderly it is seen as a structural situation, an intrinsic element of the person [17].

On the other hand, older people who have mental health problems in addition to chronic physical health problems are less likely to have effective communication, compared to older people who have only multiple physical health problems without any mental condition. It has been found that elders with mental health problems have different communication needs that individuals without mental health problems. For example, non-verbal communication activities, such as gesture and facial activity, are affected among patients with a mental problem. Elderly people with both mental and physical chronic conditions can also have a social and internal stigma because of a mental condition could affect their communication with the doctor compared to those people with multiple physical conditions without mental illness. Consequently, GPs must pay additional attention, for effective communication and achieving greater confidence, when treating patients with concurrent physical and mental conditions [18].

Empathy or lack of empathy

Even when older patients have appropriate access to medical services, they also need effective and empathic communication as an essential part of their treatment [19]. GP should pay attention to the opportunities to respond to the emotions of patients, using appropriate phrases [20].

Studies show that clinical empathy can be learned and practiced and that it adds less than a minute to the patient's interview. It also has rewards in terms of patient satisfaction, understanding and adherence to treatment [21]. The lack of empathy of the GP to the elderly patient unconsciously represents fear of old age and the fact of not perceiving the limitations of the elderly own world [22].

The disease with poor prognosis

The communication doctor-patient elder is even more complex when the GP has to confront the communication of a disease of

unfortunate prognosis to the same patient or to his family. Telling the truth is always a particularly delicate situation. Many factors intervene: the deep knowledge of the patient, the family dynamics, the sensitivity of the doctor, the patient and their relatives, the perspective of assistance, the sense of evolution of the disease, and above all, the doctor-patient relationship quality. In this scenario, the questions of how and what to communicate to the patient arise. The elderly patient has his own personal, family and social history, a peculiar course of experiences, an emotional balance of his own, and a specific way of conceiving assistance.

The communication of an uncomfortable truth cannot do without a deep respect between patient and doctor. The information must not be unidirectional, but it is modulated and oriented according to the received stimuli and the verbal and non-verbal expressions, the words and the silences, the tone, the cadence... The dosing of the information should be the result of: A. the receptive capacity of the patient; And 2. The dynamics of the doctor-older patient interaction.

The "truth" is the fruit of a common experience. It is essential to establish the authentic disposition of the elder to know the truth, in a climate of confidentiality, of colloquial intimacy. The language must be understandable and adapted to the patient's cultural level and emotional situation [17].

The doctor-older patient interview should pay special attention to psychosocial factors

GP must connect the biomedical and psychosocial aspects of clinical care. That is, the GP must give importance to the environment (contextualize). The context includes the pathology, the disease, the person and the environment. The GP must diagnose and treat the patient in the context of other factors-work, nutrition, family, personality, emotions, environment-that are in the network of the disease or the health problem. This is especially important in the interview with the elderly patient, who is more dependent and fragile in that context.

There is growing evidence that the outcomes of health care for seniors are dependent not only upon patients' physical health status and the administration of care for their biomedical needs, but also upon care for patients' psychosocial needs and attention to their social, economic, cultural, and psychological vulnerabilities. Older patients who are socially isolated, emotionally vulnerable, and economically disadvantaged are particularly in need of the social, emotional, and practical support that sensitive provider-patient communication can provide [19].

Conclusion

In conclusion, establishing an adequate relationship and communication between the elderly patient and the healthcare team, mainly the GP, is the first condition for a good medical evolution. The communication of the GP with the elderly patient has specific and special characteristics that must be taken into account in order to obtain adequate results.

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