

## Effective Patient-Physician Communication Based on Osteopathic Philosophy in Caring for Elderly Patients

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**The objective of this article is to discuss effective communication strategies between elderly patients and their physicians from the perspective of osteopathic heritage. The patient-physician communication styles of Andrew Taylor Still, MD, DO, and early osteopathic physicians (ie, DOs) may have influenced how DOs today communicate with their patients. Historical literature describes how Still would discuss with his patients the causes of their health problems using analogies and language they would understand, and how, when caring for a patient at the end of life, he empathically provided emotional support for both patients and their families. Early DOs advocated setting clear expectations for patients regarding clinical outcomes and carefully listening to patients to build trust. The Osteopathic Oath, which calls for the DO to view the patient as a friend, may also affect patient-physician communication. Early osteopathic philosophy and culture, as modeled by Dr Still in his approach to elderly patients, should inspire today's DOs in their communication with their elderly patients.**

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Patient-physician communication is a key component of the art of medicine and is central to forming therapeutic relationships.<sup>1,2</sup> However, patients often rate their physician's listening and communication skills as needing improvement.<sup>3</sup> Even though interpersonal and communication skills are 1 of the 7 osteopathic core competencies for residency training,<sup>4</sup> little has been written on the topic from an osteopathic perspective. The objective of this review is to focus on a few aspects of patient-physician communication from the perspective of our osteopathic heritage as it relates to the practice of geriatric medicine. Being aware of these aspects of communication creates opportunities to improve patient care.

### Communication Style

Although doctorate-level health care professionals share much in terms of their goals to provide the best in patient care, each profession has its own culture, history, and influential pioneers. Chiropractors have Daniel David Palmer,<sup>5</sup> and allopathic physicians (ie, MDs) look to William Osler as representing the standard of excellence for the modern physician.<sup>6</sup> The osteopathic medical profession owes its origin to Andrew

Taylor Still, MD, DO, a physician who taught his practice ideas to his students, who in turn developed their own schools, journals, and self-regulatory bodies, thus creating a distinctive health care profession with its own culture and traditions.<sup>7</sup> A study of practice differences between MDs and osteopathic physicians (ie, DOs) found that DOs were more likely to use their patients' first name, to clearly explain etiologic factors to patients, and to discuss with patients the social, familial, and emotional impact of illness.<sup>8</sup> Although more research should be done to confirm these findings, we contend that these communication style differences are not by chance but have their origins in the practice styles of Dr Still and other early DOs. The influence of these early DOs and their examples of the profession as it was envisioned are still worth our consideration, because good patient-physician communication improves patient care and satisfaction.<sup>1,9,10</sup>

If today's DOs have a communication style that puts emphasis on explaining etiologic factors,<sup>8</sup> this style may have come directly from Dr Still. Identifying the cause was central to his philosophy.<sup>11,12</sup> Although he wrote little about patient-physician communication, we have firsthand accounts of his interactions with patients. Many of these descriptions come from Arthur Grant Hildreth, DO, an early student, friend, and biographer of Dr Still.<sup>13</sup> Hildreth wrote:

Oh, what a faculty he had for selling osteopathy to those who came to him for treatment! He would examine a patient, locate what he felt to be the cause of the condition and then explain to the patient what nerve or nerves were disturbed. He would tell them how, by relieving the disturbance, the condition he found, or the pain the patient was suffering, would be alleviated.<sup>13(p42)</sup>

His formula—examine the patient, explain the cause, and explain how the treatment will alleviate the problem—is a simple but effective communication method.

Using language appropriate to a patient's level of understanding is also central to good patient-physician communication.<sup>2</sup> Modern research shows that for end-of-life communication, for example, elderly patients prefer clear explanations that avoid medical jargon.<sup>14</sup> Also, using patients' first name reflects the more informal communication style of a DO.<sup>8</sup> Dr Still's informal communication style relied on commonly understood terms and analogies. One example is an interaction between Dr Still and an elderly patient who had sciatic pain going down his leg into his toe.<sup>13</sup> After examining the patient, Dr Still commenced to treat the lower portion of the patient's spine. The elderly patient protested saying, "Why Doctor, it is not my back that is paining me, it is my limb and my toe." Dr Still smiled and said to the elderly man, "If your foot stepped on a cat's tail, you would hear the noise at the other end of the cat, wouldn't you?" This explanation both amused and satisfied the patient. Rather than explain the findings using scientific terms and anatomic jargon, Dr Still chose a simple analogy that this elderly patient from rural Missouri would understand.

Dr Hildreth gives us clues to the nonverbal communication that occurred. He says that Dr Still addressed the patient in his usual "genial, splendid way" and did so with a smile. Nonverbal signals such as a friendly disposition and good humor are believed to facilitate communication. Modern research on nonverbal communication is limited, but it does suggest that actions such as head nodding, leaning forward, and keeping legs and arms uncrossed are positive behaviors.<sup>15</sup> One randomized controlled clinical trial found that wearing a facemask substantially reduced patients' perception of empathy from physicians.<sup>16</sup> Although facemasks limit the spread of infectious disease, they also create a nonverbal communication barrier between the patient and physician. This potential communication barrier should be kept in mind lest a message of emotional withdrawal be communicated.

## Setting Expectations and Encouraging Hope

In the context of terminal illness, emotional withdrawal from patients has been identified as a barrier to communication.<sup>17</sup> Dr Hildreth tells the story of his father, in whom progressive dysphagia developed. Although Dr Still's manipulation treatments gave Mr Hildreth temporary relief, his condition progressively worsened. Dr Hildreth wrote:

Dr Still came to us many times during that year and I shall never forget his last visit, during the remaining days of April or the first few days in May, before father passed on. Just at dusk on a cloudy and gloomy day, one of severe suffering for father, we heard foot-steps on the porch at the front of our home. The door opened and in walked Dr Still with the remark, "I felt you people might need me, so here I am."<sup>13(p6)</sup>

Despite Dr Still's best efforts, Dr Hildreth's father eventually died; yet, the family was pleased with the care he received. Why would they be pleased? First, Dr Still was physically and emotionally present for both the patient and the family. Second, he was able to lessen the patient's suffering. Physicians who understand the value of palliative care and their role in making patients more comfortable should theoretically be less likely to feel emotional withdrawal. Third, putting effort into the care of a dying patient and support of his or her family is recognized and appreciated. At some point, the family was no longer hoping for a cure but wanted only for their family member's suffering to end, and they deeply appreciated Dr Still's palliation of symptoms. Dr Still exceeded their expectations by showing up at the homestead, having had to walk miles out of his way through the spring mud.<sup>13(p6)</sup>

Managing patient expectations is widely recognized as a critical component of patient care.<sup>18-21</sup> In 1910, Frank M. Geeslin, DO, who practiced in a small rural town in southwest Missouri, wrote a review paper discussing the osteopathic management of pneumonia.<sup>22</sup> The last paragraph concerns itself with setting expectations. Geeslin

cautioned that not every case will be cured, because of factors such as noncompliance with instructions and comorbid conditions, such as heart or liver disease, alcoholism, advanced age, or very young age. He advised that physicians should carefully explain to patients the prognosis of their conditions and ends the paper with this sage advice: "Always bear in mind it is better to do more than you promise, than to promise more than you can do."<sup>22</sup> Physicians should communicate realistic expectations and then do just a little more.

Balancing the principle of giving patients hope with that of setting realistic expectations is difficult.<sup>2</sup> Balancing the benefits vs the burdens of treatment in persons with chronic disease and limited life expectancy is common in geriatric practice. Therapeutic hope is beneficial and should be promoted. However, when physicians promise more than can be done, the patient-physician relationship becomes compromised. The overly optimistic view that all elderly oncology patients have the potential to exceed treatment expectations has been characterized as the "Lake Wobegon effect."<sup>23</sup> For those unfamiliar with Garrison Keillor, the public radio storyteller typically closed his monolog with the line, "Well, that's the news from Lake Wobegon, where all the women are strong, all the men are good looking, and all the children are above average." False hope and optimism can be generated by quoting outcome studies of younger cohorts that have limited generalizability to elderly individuals, leading patients to choose treatment options that are ineffective and debilitating.<sup>23</sup> The process of communicating realistic expectations can best be achieved through honesty.<sup>2</sup> For the families of patients with slowly progressive and ultimately terminal disorders such as Alzheimer disease, an understanding of what to expect reduces anxiety and makes it easier to cope with the disease.<sup>24</sup> This knowledge is especially important in cases of dementia, in which pharmacologic treatment is of limited benefit and generally not worthwhile if adverse effects occur.

Satisfying expectations is a challenge in persons with impaired memory, because everyone assesses improve-

ment based on memory. Patients with memory loss are less likely to recognize improvement in pain or function after treatment. For instance, if patients with early dementia undergo a procedure to relieve chronic knee pain, they may have limited satisfaction with the outcome simply because they lack the capacity to remember their preprocedure symptoms. For this and other pragmatic reasons, it is common in geriatric medicine to bring family, friends, and other caregivers into the health care plan decision process.

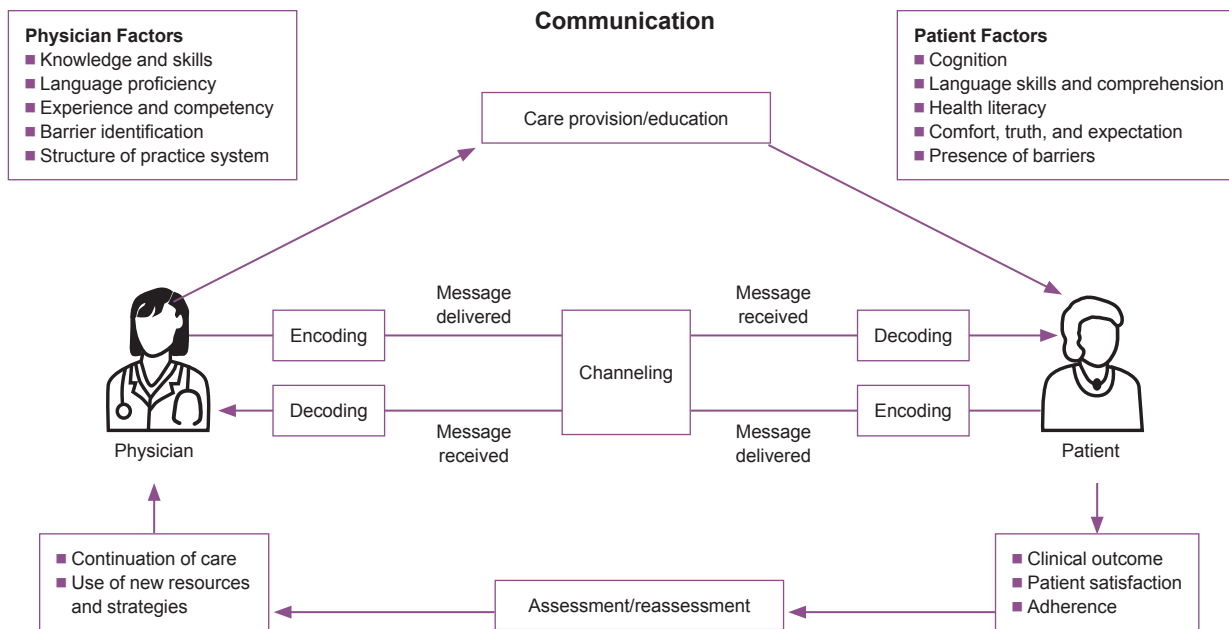
## Cooperation and Information Flow

Although family and friends are key allies in the successful execution of a health care plan, gaining the cooperation of patients and families can be challenging and can require considerable communication skills. An often-told story is Dr Max Gutensohn's house call on a noncompliant elderly female patient who kept a pan of water under the bed and a kitchen knife to cut the fever.<sup>25(p75)</sup> In the version told by Dr Gutensohn himself,<sup>25(49:30)</sup> the pan of water was a poultice (a homemade remedy made with warm water and medicinal herbs often applied to a body surface to relieve inflammation). The student doctors had been unsuccessful in getting the family to cooperate with prescribed treatments. The family was poor; their home had a dirt floor. They had their own beliefs as to what would cure the woman and little faith in doctors. When the physician arrived, the daughter was boiling up a poultice, which she was sure would cure her mother. Dr Gutensohn knew what he wanted to prescribe and that his medications would help. Rather than discuss his treatment plan, however, Dr Gutensohn dipped his finger in the poultice, tasted the water, and said, "You gotta add a little bit more salt." The daughter said she would, and the next day told Dr Gutensohn, "You know that poultice, that little more salt helped it." Dr Gutensohn recognized the family's strong belief in the poultice and the therapeutic value of that belief. He explained that although the patient did not have much belief in him, if she had belief in the poultice

and took the medication he gave her, he knew she would get well. Because Dr Gutensohn showed respect for the mother and daughter's beliefs, his recommendations were accepted, and the patient complied with the medications he prescribed. The anecdote emphasizes that patient-physician communication is a 2-way proposition.

The flow of information in a clinical encounter is a mutual process; it flows from patient to physician and vice versa. Travaline et al<sup>2</sup> list 9 tips for facilitating good patient-physician communication: (1) assess what the patient already knows; (2) assess what the patient wants to know; (3) be empathetic; (4) slow down; (5) keep it simple; (6) tell the truth; (7) be helpful; (8) watch the patient's body language and facial expression; and (9) be prepared for a reaction.<sup>2</sup> Obviously, a good understanding of a patient's problem and its appropriate management gained through meaningful communication is an integral part of a good patient-physician relationship. The last 2 tips (watching body language and being ready for a reaction) highlight the interactive nature of patient-physician communication.

An experienced physician analyzes not only the verbal messages but also the nonverbal ones that patients intentionally or unintentionally put forth. In an encounter, messages are generated, encoded, channeled, decoded, and perceived. The *Figure* depicts an example of this process. Of course, the flow of the message may be affected at any stage by many different factors. Some factors may facilitate the exchange of information between patient and physician and some may adversely affect it. The attitude of office and clinical staff, the atmosphere of the waiting room and examination room, patients' expectations and health literacy level, physicians' understanding of and empathy toward patients' situation and knowledge about patients' condition, and language used to discuss medical information are some of the factors that may affect communication.<sup>2</sup> Patients feel more cared for when such a meaningful therapeutic relationship, developed through effective communication, with a patient and physician.<sup>26,27</sup>



**Figure.**

In a patient-physician encounter, messages are generated, encoded, channeled, decoded, and perceived. Various factors affect the exchange of information, either facilitating or adversely affecting communication.

## The Osteopathic Oath and Friendship

The majority of medical schools and health care professions administer an oath or practice pledge.<sup>28,29</sup> Most are variations of the Hippocratic Oath and serve to reflect the professions' moral values and standards. Survey data suggest that 63% of medical school graduates indicate that these oaths influence their practice "a lot" or "somewhat," and 37% indicate that these oaths influence their practice "not very much" or "not at all."<sup>28</sup> Osteopathic medical schools follow the Osteopathic Oath, which was first proposed by Frank E. MacCracken, DO.<sup>30</sup> The proposal gained national support from both the American Osteopathic Association and the Associated Colleges of Osteopathy, and the oath was first used in 1938 and then slightly modified to its current form in 1954.<sup>31</sup> A subtle but important idea is imbedded in the Osteopathic Oath when

the physician pledges "to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity." The oath contains the idea that friendship is a component of the patient-physician relationship. This message is in contrast to the older medical model of paternalism.<sup>1</sup> Viewing patients as friends changes the nature of patient-physician communication.

## Conclusion

The osteopathic medical profession today is fortunate to have inherited a practice culture that favors good patient-physician communication. Effective patient-physician communication is pivotal to a successful relationship between patient and physician and to the healing process. Various styles of communication exist, and no one style

should be considered as the criterion standard—communication style should fit a physician’s personality and practice. The art of creating a warm, sensitive, and empathetic environment speaks volumes to a person who is in need of healing. Respect for the patient’s values and belief systems, clear translation of scientific information to meet the patients’ level of understanding, and good listening skills are all important to form a good bond between patient and physician and may very well diminish the complexities that challenge the patient-physician relationship, providing opportunities for improved outcomes.

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