Communication skills in caring for older people

Good communication skills are essential, particularly in the care of older people. Interactions between doctors and patients or patients' relatives will increase since the arrival of lasting power of attorney, implemented with the Mental Capacity Act in 2005. This article looks at the special nature of communication between the doctor, older patients, and their relatives. We also present a model of good practice in communicating with the relatives of older patients.

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Doctors dealing with patients need to have excellent communication skills, and this has been clearly understood for many years. Inadequate communication reduces patients' perceptions of the quality of the doctor–patient relationship. It can lead to the more serious consequences of misinterpretation, dissatisfaction, and inaccurate decision-making that result in formal complaints and litigation.

Poor communication is a frequent cause of litigation,[1] which is a major concern for doctors working today.[2] Health-care practitioners working with older people need to demonstrate a particularly high calibre of communication skills in dealing with patients and relatives in often challenging situations.[3]

The redesign of medical education and training through Modernising Medical Careers places much greater emphasis on teaching communication skills through the foundation programmes: skills are now actively taught at both undergraduate and postgraduate levels with proven results.[4–7]

Physicians in medicine for older people are more commonly requested to speak with the next of kin than are those working with younger patients. The Mental Capacity Act, 2005,[8] which was enacted in October 2007, has introduced us to the concept of lasting power of attorney. This involves nomination of proxy decision-makers, which will also increase the frequency of discussions about patients with third parties.[9] In the education of doctors in training the focus of communication skills is usually the patient rather than their relatives.

Ethical and legal considerations

The relationship between an older patient and their doctor is essentially the same as for younger adults—when competent, the patient should always be at the centre of all decision-making and interactions with medical staff. Confidentiality should be preserved and consent sought before any information is passed to third parties. However, medical staff often talk to the relatives of older people before or instead of patients.

Elderly patients more frequently have conditions that hamper normal forms of verbal and written communication such as deafness, poor vision, dysphasia, dysarthria, drowsiness or confusion, making communication very difficult. Acknowledging that, culturally and traditionally, society has sometimes adopted a parental role in its treatment of older people is important. Relatives or next-of-kin may have become the focus of information about the patient, and have replaced the patient as the primary decision maker without consideration of either whether this is appropriate or if the patient's consent has been sought. Elderly-care physicians may be approached by families requesting that medical staff to speak to them first and wanting the power to decide what information is given to the patient. These requests are usually well intentioned but may be ethically difficult.

This issue was clarified with the Human Rights Act:[10] article 10 states that the patient has the right to hold opinions and receive information. The act is also incorporated into The NHS Plan, which places emphasis on the need for autonomy.[11] Therefore, in a competent patient, seeking verbal consent from the patient is

Box 1: Reasons for relatives speaking with doctors

1. To obtain details of the clinical situation or, in cases of sudden death, to help them to understand the causes and adjust to the bereavement
2. To clarify the clinical situation if they have been given or have perceived to be given conflicting information from various sources
3. To offer information that may help or change clinical care
4. To discuss the prognosis for the patient's condition
5. To express the patient's reflected views of treatment options or limitations to care
6. To express their own views of treatment options or limitations to care
7. To raise concerns or make complaints about treatments
8. To voice concerns about ageism
9. To discuss planning for the patient's discharge from hospital

appropriate if a relative wishes to speak to a doctor in the absence of the patient.

In case of an incompetent patient, for example, with acute or chronic cognitive impairment or a reduced level of consciousness, the issue is more difficult. The doctor's duty is to provide care to the patient as their first concern.[12] Involving relatives of incompetent patients in decision-making has long been regarded as good practice, although until recently there was no obligation. Under the Human Rights Act, we may breach article 8 if we do not involve the relatives of incompetent patients in the decision-making process. It states "those close to the patient… have a right to information and… involvement in discussions" about incompetent patients.[10]

The implementation of the Mental Capacity Act 2005[8] in October 2007 led to the arrival of lasting power of attorney for medical decisions; thus formalising and augmenting the involvement of next-of-kin in decision-making processes for various groups of patients, including older people.

Legislation has existed in Scotland for some time, and has now been adopted for England and Wales, such that competent patients, young or old, will have the right, and a process, to nominate a medical decision-maker. In the event of the patient later becoming incompetent for whatever reason, the nominee can act as their advocate. We should now be prepared for more frequent liaisons between doctors and the patient's proxy decision-maker. This will often be a close relative or friend. However, if the patient lacks capacity and has no one to speak on their behalf, the NHS can now appoint an Independent Mental Capacity Advocate, who will consult with staff and act as the patient's advocate to help determine what is in their best interests.

Most communication with patients and relatives is verbal, but increasingly written documentation of such interactions is essential. A formal letter to the patient and relative summarising the meeting and agreed future plans may also be useful. This is particularly true in meetings in which complaints have been voiced, emotive subjects have been discussed, or the views of family members or health-care professionals differ.

Establishing the reason why relatives have requested a meeting and their agenda can be very helpful. This usually takes little time and improves the efficiency and outcome of the discussion.[13] Common reasons that relatives request to speak to doctors about the care of older relatives are shown in box 1.

A model of good practice

All consultations should ideally be held in a private location with the patient's prior consent to discuss their medical issues with the participants.[10,12] The meeting should include the appropriate and identified next-of-kin, lasting power of attorney or independent mental capacity advocate. It should be chaired by a member of medical staff with sufficient knowledge of the clinical case and the ability to answer relatives' questions. Appropriate support should be sought from professionals allied to medicine. Sufficient time should be given to allow such interactions without interruptions.

Step 1: Introductions

Introduce yourself and staff present and ask relatives to introduce themselves. Many relatives will be unaware of the roles of individual members of staff and the hierarchical structure within medicine. Therefore, an early explanation of the staff present and why they are involved may be helpful.

"Can I introduce myself and the rest of the team involved with the care of your relative?"

Additionally, patients often have more than one son and daughter: identifying exactly who is present, and who is absent, may prevent later errors. This may also identify the conflicts of interest and differing opinions between family members.

"So that I know who I am talking to, I would be grateful if you can let me know who each of you are and your relationship to the patient."

With large families, asking the patient or family to nominate a representative to disseminate information can be helpful. This can, however, cause problems if family members have differing agendas.

Conduct

The doctor should make eye contact when meeting the participants for the first time,[14] and show both verbal and non-verbal empathy.[15,16] Relatives' questions and objections should be responded to and explored; never ignore or undermine a relative's comments, however obscure they appear.

Look, listen, and respond to visual and spoken cues: heavy sighing and fidgeting can reveal as much as crying and shouting.[15,17] One study estimated that 93% of information exchanged during a conversation comes from body language and tone of voice.[16]

Be aware of the cues that might indicate an emotional state. Although one relative may do all the talking, notice the quiet one at the back that may develop anger if their opinions and feelings are not taken into account. Check relatives' understanding and clarify unclear statements, then focus and redirect the relative appropriately. Comment upon observed feelings.

"You seem worried by this."

"Is this something that concerns you?"

Step 2: Explanation of processes

Although the doctor should make every effort to not dictate the meeting's agenda or appear to dominate a meeting with relatives, acting as coordinator to give the meeting structure is often helpful. This is especially useful for meetings with large family groups or large numbers of allied health-care professionals. Facilitation of a meeting in this way ensures that all participants feel included.[18]

Determining issues on which to focus jointly with relatives is important. Even if a doctor has a fairly clear understanding of why a relative may wish for a meeting, it is almost universally useful to recap or clarify with a summary of the clinical situation. Many misunderstandings can be avoided if assumptions about clinical care are dealt with early in the consultation.

However, if a doctor launches into a description of the situation as they see it, they may undermine fundamental principles of good communication. Good communication between two people involves the need for both people to be allowed to speak, to be heard, and to create dialogue. Good care involves the development of a joint understanding of the situation: relatives may have information that places a different emphasis on how a situation should be seen.

"I am sure you have a lot of questions you will want to ask me. What I often find helpful is to summarise my understanding of your relative's condition, and what I know about their general health. You can then ask questions and put me right on anything that is incorrect or is inaccurate. Is that okay?"

"Can I ask what you already understand about your relative's condition?"

In a hostile environment, the second approach may be more difficult and can open the floodgates for the voicing of issues that occurred prior to your involvement with the patient and, thus, beyond your control.

The first approach prevents important topics being overridden in a discussion of issues of less immediate relevance by allowing the relative to set the initial agenda on the basis of misunderstandings. It also avoids the doctor appearing to know all and an acknowledges that the relative's information, questions and views are important. An intention to allow time for questions, and for the relative's voice to be heard is clearly stated. Finally, it avoids immediate questions about delivery of care before the current hospital episode—although it is always good to listen to these points sympathetically, even if not offering specific commentary.

Step 3: The clinical vignette

This should include the patient's residence status and level of physical and mental function before admission.

"From what I understand, Mrs X has been living at a residential home for the last 3 years since her memory started to deteriorate. She has been fairly physically fit. She was admitted to the emergency department 2 weeks ago after collapsing. Tests revealed she had a stroke. This is a blockage of the blood supply of part of her brain. It has affected her speech and movement on the right side of her body."

Detail how long the patient has been in hospital under your care. Describe the course of clinical events, including past medical health and the present situation as you see it.

"She has been under my care since she arrived on this ward. She has already started to improve and I have reports here from the speech therapist and physiotherapist…"

Give the patient's general prognosis, and the anticipated discharge date and process— but only if there is a high degree of certainty, otherwise the prognosis and discharge details are probably best left until after your conclusion and summary.

"The amount of recovery we can expect is difficult to predict, however, to maximise her potential we will be

arranging a bed for Mrs X on our stroke-rehabilitation ward and the whole team will review her progress on a weekly basis. As she has already made some progress, we hope that will continue. Unfortunately, there is a chance that she may not recover her physical independence, or instead her condition could deteriorate. This would mean she might need more nursing care in the future than her residential home can provide."

Many older people and their relatives have a greater understanding of medical issues than medical staff would think. The danger is of patronising clients with over-simplification of clinical situations and offering an inadequate and sparse description of care options.

Particular attention should be given to using simple and understandable language and avoiding medical terminology. Frequent breaks in the flow of information allows clarification that relatives have understood the information offered so far. Consideration should be given to the family's knowledge base and cultural understanding of health care. To facilitate opportunities to ask questions and seek clarification, allow the relatives to interrupt and ask questions. Clarify points if they do not understand or appear confused.

Prognosis

Requesting the prognosis of any particular medical condition is normal and natural. Junior medical staff often do not contextualise this information in relation to comorbidity or natural life expectancy. A prognosis of a patient aged 95 years might gently be explained to not be significantly different to that of all 95 year olds. Localised prostate cancer, for example, often does not alter life expectancy. It is not an uncommon finding at post mortem when it was not suspected in life. A common request is for a numerical estimate of prognosis.

"About 3 months"

This can be heard as a definite 3 months in an emotional situation. Offering general rather than specific timeframes is advisable in first conversations.

"Unlikely days, probably months, less likely years."

Step 4: The relative's perspective

Allow the relative to express their views and give them an opportunity to ask further questions. This will engender a discussion about the situation and hopefully reach agreement.

"Have I missed any other points?"

"Have I misunderstood anything?"

"What questions do you have?"

Step 5: Ensuring the patient's views

Relatives must be aware of what information has been given to patients and the ethical frameworks for further discussions or decisions about the patient's care should be explained. In the case of patients judged unable to decide or to contribute to decisions about future care, clarity about the difference between the next of kin reflecting the patient's wishes versus the wishes of the next of kin themselves should be explained.

"If your relative, Mrs X, had been able to make her own decisions about her treatment, do you think she would be happy with the treatment and our future plans for her?"

Step 6: Summary and conclusion

Give a brief summary of the meeting including the medical diagnoses affecting the patient while in hospital; a prognosis for the current illness, if appropriate; an acknowledgement of the relatives' concerns; an agreement between the parties on a course of action; and an opportunity to ask any further questions.

"…. and finally, do you have any further questions?"

This is a positive gesture that ensures you have not missed any issues that the relative may still have. It can also help relatives feel that they have had all their issues dealt with and listened to as they leave the meeting.

Document the meeting in the patient's medical notes and consider writing a letter to the patient and relatives. This is especially recommended if contentious issues have been discussed and disagreements voiced between the relatives and health-care professionals at the meeting.

"Dear XYZ,

I would like to summarise and document the items we discussed at our meeting today concerning your relative Mrs X…I would also like to confirm that you were happy with our discussion today and agreed with the proposed medical plan."

Summary

Communicating with the relatives of patients can be challenging—legally, morally, and technically—particularly when dealing with older patients. Issues of patient's competency, autonomy, and confidentiality are important.

Elderly patients are one of the most vulnerable groups in society and, as such, relatives can often feel protective about their medical care and frequently ask for discussions with staff regarding the patient's care. This will only increase now that patients can appoint lasting power of attorney. We should prepare for an influx of these requests and realise that with a little forethought and preparation, meetings and discussions can run smoothly. The aim is to ensure that all parties are satisfied with the process and that the best care plan is achieved for the patient.

We have no conflicts of interest.

Key points

1. Good communication skills are essential for all health-care professionals involved in the care of older people
2. Communication with relatives is more common with older people than with younger people and raises important legal and ethical issues
3. Interactions between doctors, patients, and relatives will increase with lasting power of attorney
4. Understanding the reasons why relatives request such meetings is important, as is responding appropriately to cues and reactions within the meeting
5. Doctors can act as coordinator of these meetings, without dictating the agenda, to give it structure. This can enable productivity to the satisfaction of all and ensure the best care plan is achieved

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