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## **Exploring Physician-Older Patient Communication. A Qualitative Analysis of Communication between Older Patients and General Practitioners**

### **Abstract**

An great body of research has been carried out to study physician-patient communication and its impact on quality of care, patient satisfaction, treatment and health. Good physician-patient communication is proved to increase patient's health. Most of the existent literature on the field has been done on younger patients and only a small part of the studies conducted took into consideration the older patients' communication and relationship with their doctors. We depart from the idea that age has an important role in doctor-patient interaction, as age moderates the relationship between the style of interaction and patient satisfaction.

This study aims to explore the physician-older patient communication by analyzing the way elders experience the relationship with the general practitioner. By doing so, the current study looks at the way elders perceive their relationship with the general practitioner and the level of their satisfaction. Elements like tone of voice, forms of address, topics, explanations given, motifs of the visit have been considered in the present study in order to explore de doctor-older patient communication.

**Keywords:** physician-older patient communication, older patients, health communication.

### **Introduction**

There is a great deal of research studying old people from a great diversity of perspectives and theoretical backgrounds. As individuals are living longer and as seniors are a major market segment, the focus on older people is constantly growing. It seems that with each year, seniors are becoming more attractive for both marketers and academic researchers. Looking at this focus on older people, we see that some attention is paid to health and its subfields. Older peoples' health, together with health care programs and physician-older patient communication have been put into spotlight by academic scholars (Haskard Zolnierek & DiMatteo, 2009; Adelman, Greene & Ory, 2000; Williams, Haskard & DiMatteo, 2007; Levin-

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son et al, 2010), many of them aiming to explore the impact that communication has on the health status of the seniors and on access to health programs for them. Existent research reveals that communication with older patients has important features when compared with younger adults as in the case of older people the emotional and affective care are essential for the health status (Williams, Haskard & DiMatteo, 2007).

However, although health communication research is growing, we still have few empirical studies investigating the physician-older patient relationship and communication. Few studies that we know of are available in South-Eastern European countries, mainly in Romania, where health communication is less acknowledged and explored. By looking into the way Romanian older patients communicate with their doctors, we hope to widen the existing Western discourse on the topic. Having in mind that there is evidence on context specific physician-patient communication (Britten et al, 2000), we are interested to see if the analysis conducted in Romania of the way older patients communicate with the doctors is in line with the existent literature on the field. In this respect, the current study aims to shed a light on how older patients from Romania communicate with their doctor and the dimensions of their relationship. Through a qualitative research, this study seeks to understand physician-older patient communication, by looking at how older patients perceive communication with the general practitioner.

### **Physician-older patient communication. Evidence from previous studies**

The physician-patient relationship has been documented for more than 40 years, proving that good communication between the doctor and the patient has a significant impact on patient health status, patient satisfaction, health programs and health budget (Haskard Zolnierek & DiMatteo, 2009; Adelman, Greene & Ory, 2000; Ben-Sira, 1980). Research has been carried out to understand what good versus poor communication between physician and patient can do to the patients' health status. As studies show, patients tend to prefer physicians who engage in conversations with them and encourage them to talk about all their problems, not only the ones regarding their health (Britten et al, 2000). On the other hand, poor communication has been linked to adverse drug effects as patients did not properly understand how to use the prescription. Some studies have revealed a link between interpersonal communication skills of the physician and low number of malpractice law suits (Levinson et al, 2010), as it was showed that good communication with patients leads to a lower number of malpractice cases.

Also, research has been carried out to explore how interaction and communication between doctor and patient leads to the improvement of health conditions of the patient. As in the case of many other fields, analysis done to study physician-patient communication is overwhelming for adults and children and less developed for older patients (Williams, Haskard & DiMatteo, 2007). In many cases, some of the findings from other age groups have been extended to old patients and thus many of the conclusions regarding physician-older patient communication are not very solid. Although communicating with older patients has been compared with younger patients, studies show that older patients have significant particularities, as the emotional care has been proved to be more important than in the case of other age groups of patients (Adelman, Greene & Ory, 2000).

Drawing on the existent literature on the field we see that physician-patient communication has very important implications in the case of elders, for both their physical and mental health (Adelman, Greene & Ory, 2000; Williams, Haskard & DiMatteo, 2007). Both quantitative and qualitative research have revealed a direct link between poor physician-older patient communication and health status decrease and health improvement and patient satisfaction in the case of good communication. This growing evidence has led to the setup of medical communication guides for general practitioners taking care of older people (Levinson et al, 2010; Adelman, Greene & Ory, 2000; Williams, Haskard & DiMatteo, 2007). Mostly interesting is that not only health organizations and medical institutions and care providers are doing this. Many of the academic papers available on the topic include recommendations for physicians on how to communicate with older patients in order to improve health status. Academic scholars and health experts acknowledge doctor-patient communication as they consider that it has a direct impact on older persons' health.

Another important aspect underlined by previous research is the presence of ageism in the medical care. Ageism can determine medical care (Adelman, Greene & Charont, 1991; Adelman, Greene & Ory, 2000), as it was documented that sometimes older patients don't receive proper medication and treatment as their health problems are attributed to the aging process. The most common ageism is the inter-generational discrimination, when older people are considered inferior to younger ones (Bytheway, 2005). Considered to be old-fashioned and less productive, older people are seen as needy and inferior. The intra-generational ageism can be encountered in the situation when groups of old people are considered to be a good example due to how they are (depicted as active, healthy and socially engaged and most of the time labeled as still young), compared to the ones who do not fulfill these criteria and are considered inferior. Scholars review several ways of ageism in medical care (Adelman, Greene & Ory, 2000), like the fact that physicians may trivialize health problems of older people, by considering them due to the aging process. Ageism in medical care is also linked to the use of derogatory names or infantilization of the old people.

Clinical practice and research have pointed out the presence of a third person during the visit to the physician of an older patient. Records of medical visits and direct observation reveal that sometimes older patients are accompanied to the physician by a third person, this being referred to as a triadic physician-patient-other relationship (Williams, Haskard & DiMatteo, 2007). Although the third person can be of a real help for the older patient having walking difficulties or cognitive impairments, in many cases the presence of another person changes significantly the way the older patient communicates and interacts with the physician (Greene et al, 1994; Greene & Adelman, 2003; Williams, Haskard & DiMatteo, 2007). Studies show that, when accompanied by another person, the old patient tends to less engage in the discussion and not to give additional information to the doctor.

## **Current study**

Departing from the growing evidence that good physician-older patient communication leads to patient satisfaction and to a better health status of the patient, the current study aims to explore the relationship that older patients have with their general practitioner and how they perceive communication with the general practitioner. In line with the existent research, we considered that effective communication between physician and older patient means sharing

biomedical and psychosocial information, but also emotional and affective care (Williams, Haskard & DiMatteo, 2007). This exchange of information and the emotional care have been the main aspects we had in mind when exploring communication between physician and older patients.

From the early beginning of this current research, two main concerns arise. The first one regarded the selection of the medical specialization. Most of the existing research explores communication between physician and older patient in two different medical specializations: oncology and primary care medicine. As our intention was to analyze communication with patients who were not under a medical pressure, we decided to study general practitioner-older patient relationship and communication, by focusing on how older people perceive their relationship with the general practitioner. The second concern we had was how to define the older patient. Looking at the literature on the field, we see that there is a controversy about when people get old and when exactly old age begins. Gerontologists have tried to shed light on this and have considered three categories: young-old (65-74), middle-old (75-84), and old-old (85+) (see Adelman, Greene & Ory, 2000), while other researchers have considered the retirement criteria as the beginning of the old age. Social and demographical criteria have also been used in defining the old age. In Adelman, Greene and Ory's words, "nothing magical occurs at the chronological age of 65 that marks a person as older. The age of 65 was not derived from a biologic process; it was defined by social demographic data" (2000, 2). Having in mind this controversy and the fact that Eurobarometer (2012) shows that being old has different meanings in different countries as is has important cultural implications, we decided to consider the retirement criteria as the one most appropriate and relevant for the current study. Therefore, we conducted the interviews with pensioners.

## Method

This qualitative study was designed to explore general practitioner-older patient communication, by looking at the biomedical and psychological information exchanged and at the emotional care older patients receive during their visit to the doctor. We conducted 10 semi-structured interviews in Bacau county, Romania (7 women and 3 men), participants age ranged between 65 and 80. All the participants were retired in pension and had residence in Bacau county (medium size county in Romania). None of the participants were former physicians, pharmacists or medical care providers. Before retiring in pension, the participants had worked as lawyer, teacher, cashier, technician, clothier, engineer, and receptionist. The interviews were conducted in Autumn 2017 during several weeks, most of them were done at Pensioners' House in Bacau, a place for social and leisure activities dedicated to retired persons. Although it was not a criteria for selection, none of the participants had the same general practitioner as their doctor. The interviews were conducted in Romania, were audio recorded, with the informal consent of the participants and lasted from 20 to 45 minutes.

Several aspects of the physician-older patient were explored during the interviews. First, we asked for the biomedical and psychosocial information exchanged with the general practitioners. Several questions about the biomedical information exchange were asked in order to understand if the medical information prevail and how many details participants received regarding prescription and medication. During the interview, we asked participants to remember their last visit to the general practitioner and talk about it. Tone of voice and forms of ad-

dress were explored during the discussion with the participants, as well as the motifs of their visit and frequency. As in the case of other qualitative studies of the physician-older patient communication, when interviewing we also tried to understand how senior patients perceive their relationship with the general practitioner and if they experience ageism attitudes in the health care process. Questions regarding ageism attitudes were not directly formulated, the topic was indirectly addressed during the discussions with participants. Data was coded manually and analyzed considering the main themes emerging from the interviews.

## Results

### Doctor-older patient relationship centered around emotional care

Although we tried to explore the medical information exchanged between the general practitioner and the older patients, our study shows that the doctor-older patient relationship is not built on this aspect, as the biomedical information does not prevail and is rarely remembered by the participants. When asked what they talk with the general practitioner, participants first mention social and family related topics and only rarely they briefly mention that during the visit they engage in health related discussion topics. When doing this, participants say that they go monthly to the general practitioner to get prescription for their daily medication, as indicated by the specialist.

“I go to my general practitioner monthly because I need my prescription for my daily care. I also go to prevent, you know ... you can make some tests every six months or annually.” (Woman, cashier, 67 years old).

If the biomedical information is rarely mentioned by the participants, the situation is quite different in the case of the emotional and affective care. When asked to describe their general practitioner, participants do not mention the medical competence, know-how and expertise, instead they mention how friendly the doctor is and how close they are. The relationship with the general practitioner is defined through words like friendly, mother, mother-daughter, and is considered to be a solid, long term relationship. When asked to remember the topics of their discussion, one participant says:

“We talk like mother-daughter, she is quite young, in her 40s, but this is OK, we go along very well. We also talk about cooking recipe, cakes and things like this.” (Woman, cashier, 67 years old),

while another one mentions:

”The general practitioner I go to is so well meant ... he always considers my age and this is very important for a patient, as the patient feels the doctor is there for him, this is why we call him a family doctor (name of the general practitioner in Romanian). I honestly tell you that he knows a lot of things about my family, that I lost my wife and I am living alone now, that I cook for myself.” (Man, lawyer, 67 years old).

The medical knowledge of the general practitioner is never brought into discussion by the participants. Still, the participants acknowledge the fact that they visit the doctor for care, but this care is represented as a family care, and not as a medical professional care. The friendly and family-alike relationship participants have with the general practitioner picture the doctor as a mother taking care of her children. The connection is considered solid and trustworthy by the participants, but this is due to the features mentioned above and not based on

the medical expertise of the general practitioner. Care and taking care of us are frequently used during the interviews.

“(The doctor is) very friendly. She is just like a mother. Because only a mother knows when we are in pain and what to do. Just like a mother, our family doctor knows exactly what’s going on with us and what’s not going well.” (Woman, technician, 80 years old).

The relationship with the general practitioner is perceived as a long term and solid bond. These features seem linked to the age of the patients, as participants mention that their general practitioner knows how to take care of seniors and that after so many years they have come to get to know each other very well. Being close to older people’s needs is considered important, as one participant states:

“I think that she (the general practitioner) is very close to old people’s needs ... you see, usually elders go to the general practitioner for prescription ... every month ... so we get to build a solid relationship, we know each other for years.” (Woman, technician, 80 years old).

Respect is another aspect mentioned by the participants in the current study, especially by the ones with a higher professional status, like the case of the former layer. Still, when talking about respect, participants link it to the age of the patient and not to patient’s profession or former workplace. Although respect is considered to be triggered by age, only participants with higher professional status talk about it.

“The doctor respects us due to our age and because we have a long-term relationship, we know each other for years, he knows almost everything about us. We had situations when he told us on the phone what medicine to take.” (Man, teacher, 72 years old).

Sometimes, the fact that the patient shares memories with the doctor is very much valued and considered to be very important for a good cooperation. The fact that they know each other for many years and that they know details about each other’s family leads to a positive representation of the general practitioner and enables trust.

“We are neighbors. I have seen her growing up, she is a young lady, very fond of her patients, including me and my family. Children in our families played together, she has a daughter. We share nice memories, so we collaborate very well.” (Woman, teacher, 70).

### The visit to the general practitioner as a social activity

Most of the participants mention going monthly to the general practitioner as they need a new prescription every month for their daily medicine. This visit is integrated in the older patient life routine and functions as a social activity and nostalgia of an active life. The family related topics addressed during the visit, the friendly environment, along with the fact that participants feel that older patients’ needs are being considered, make the visit to the general practitioner a pleasant one and part of the social dimension of the older person.

“I go quite often to my doctor. My general practitioner tells us to come, to check our health, to see if we are OK. Or just to see how we look and to see what we need.” (Woman, secretary, 72 years old).

while another one mentions:

“If it is necessary the visit can last a little bit longer. I was in that situation, several months ago, because I had some complicated problems that weren’t in her area of competence, but she supported me all the way in order to solve them.” (Woman, teacher, 64 years old).

In that sense, the respondents refer to their general practitioner as a friend, part of their family, associated more with a psychologist or a priest. The visit to the doctor becomes an important part of their social life. The need for prescriptions or medicine is a real fact, but also a pretext for going out of their houses, in order to share their family problems or to socialize with others older patients.

„As a patient I never had any doubts talking to my doctor about my family. I lost my wife and she (the general practitioner) immediately advise me to go to a psychologist because after the death of a close person you must face a lot of emotional problems that can affect your health status.” (Man, clothier, 71 years old).

The social activity dimension of the visit to the general practitioner is part of the emotional and affective care of the older patient. During the visit, participants feel free to talk about the situation they have back home and their needs as older persons. The fact that the doctor acknowledges the age of the patients is seen important by the participants, as gives them the impression that they receive tailored care.

“Usually, she (the general practitioner) asks about my mother, what is she doing and how she is feeling. She also has older patients and that makes her sensitive; She empathizes with my situation because one day she will be in the same position.” (Woman, teacher, 65 years old).

Sharing news about the family members becomes an important part of the conversation between doctors and their older patients in order to make a friendly atmosphere where they feel like home or spending time with a friend.

“She (the general practitioner) asks about my son, about our everyday life; we also talk about other subjects, beyond the medical problems (...) she is a person open for discussion, never so busy to refuse a conversation with a patient.” (Woman, cashier, 67 years old).

Interviews also revealed that older patients taking part of our study have significant confidence in the general practitioner and this is very much linked to the personal relationship built between them. As in the case of other aspects, confidence is not built on the medical expertise, it is linked to the emotional and affective care the general practitioner offers to the older patients. Knowing the personal and family problems of the older patient and showing interest for the other aspects of the patients' life generates confidence:

“In doctor-patient relationship it is very important to have confidence. This becomes a significant aspect of our treatment. If we have enough trust in what the doctor says and recommends for us, we are half cured. I especially trust very much in my doctor because she knows my personal life. Sometimes the doctor realizes what is wrong with us because she knows how we feel inside.” (Woman, receptionist, 80 years old).

Knowing details about the patient, both regarding the family and the personal history make the general practitioner trustworthy. The fact that the general practitioner knows things about the patient is considered to be a friendly approach, as one participant says:

“My doctor is very careful with me. I go more often to the general practitioner than to the specialist. So, he knows my history concerning my medical problems, the diseases I had in the past, how I react to a certain treatment, if I am allergic to some medicines and that makes the whole approach more friendly.” (Woman, confectioner, 73 years old).

### Communication style and professional status of the older patient

Data shows that general practitioners use different communication styles depending on the patients' professional status and age. When asked how does the general practitioner calls him/her, participants say in a very friendly way, friendly, makes jokes, like a mother, considering this as a nice, warm and appropriate communication.

"My doctor is very diplomatic, she speaks very nice. It's not that I want to compliment her, but I go to visit her because I am very fond of her." (Man, engineer, 68 years old).

The informal ways of addressing are linked with the profession of the older patient. Participants previously working as educators seem to appreciate the warm approach of the general practitioner and the fact that they feel respected by the doctor. The fact that they are asked from the early stage of their visit How are you doing on a gentle voice is very much appreciated. This also triggers a maternal approach for older patient which is highly valued by the participants.

"The first questions is How you are doing? with a gentle voice, just like a mother for us, the older persons." (Woman, teacher 69 years old).

It is worth mentioning that this maternal approach is coupled with the need to feel respected by the general practitioner, especially for the professional status of the patients. All the participants with higher professional status (teacher, engineer, lawyer) appreciated that the doctor respects them. They underlined this by saying the doctor respects me, we respect each other, the doctor knows I worked as a teacher/engineer.

"She knows I was a teacher. We respect each other, I respect her job and she respects mine's." (Woman, teacher, 65 years old).

Communication style changes when the general practitioner talks with the old-old category of patients. In the case of 85+ patients we encounter infantilization elements of communication, which are considered proofs of care and warmth. As one participant tells:

"She is very nice, for instance with my mother she speaks very friendly, calling her mămăi?ă [little granny in Romanian], warm words, sensitive, more emphatic with my mother compared to me, because she wants to convince her to follow her prescription." (Woman, teacher, 65 years old)

Interviews show that when talking with older patients, the general practitioner uses different communication styles, taking into consideration the patients' professional status and age. The mother figure for older people, along with partners showing equal respect and consideration are the main elements that describe the communication style of the general practitioners. However, in some cases, when the patient is 85+, communication changes and encloses infantile ways of addressing and talking.

## Conclusion

The semi-structured interviews conducted with older patients in Bacau county, Romania revealed some interesting findings. Some of these findings are not clearly in line with the existent literature on the field, mainly because previous studies have been done in different social and cultural contexts. The findings that we consider in line with the literature on the field are on one hand, the link between patient satisfaction and physician-older patient good com-



munication, and the high importance of emotional care in the case of older patients, on the other hand. Thus, the current study underlines the fact that for older patients the emotional and affective dimension can determine patient satisfaction and access to health services. Although briefly explored in this study, group care sessions for older patients (Adelman, Greene & Ory, 2000) might have a huge value for the care of older patients, as they would benefit from the possibility to talk in a friendly environment about their health status, with people of their own age and having similar health difficulties. As largely mentioned in previous studies, the visit to the physician needs to be a psychological, social and emotional experience in the case of older patients (Adelman, Greene & Ory, 2000; Williams, Haskard & DiMatteo, 2007; DiMatteo et al 2002).

The current study also shed a light on findings that haven't been explored in existent literature on the field, like the feeling of belonging encountered in the relationship with the general practitioner and the maternal care perceived by the older patients. Most of the participants referred to the doctor as their own general practitioner, symbolizing a sense of belonging and a very close connection. This may be context relevant, as in Romanian the general practitioner is called family doctor and free medicines or half paid ones can be procured only with prescription from the general practitioner. Also, data from the interviews shows that the medical expertise of the general practitioner is never addressed, while the maternal care is frequently mentioned and considered very important. The general practitioner is seen as competent and worth to compliment because she/he is aware of the personal and family life of the patients and shows care for these. Knowing personal details about the patient and engaging in conversations about his daily activity creates a solid bond between the two of them. The relationship with the general practitioner is built along the years and is described as a maternal care, a maternal figure for older people and respect for the old patient. The visit to the general practitioner is relaxing and gives the older patient the possibility to talk and to be listened. In many cases, the interviews revealed that participants engage in the relationship with the general practitioner in a similar way as with a close friend, whom they care, share personal and intimate thoughts. Mostly interesting, the visit does not only serve as a social activity, but also has a deep psychological meaning, as the general practitioner has a role similar to a priest, psychologist or personal coach. By acknowledging the emotional problems of the older patient, being constantly preoccupied with the patient's needs, listening and engaging in small talk, the general practitioner is offering something similar to psychological assistance.

The topics addressed during the visit reveal a powerful emotional relationship, as participants talk about their family events, their longlines, but also about cooking and other house related activities. The general practitioner is providing emotional and affective care, just as mothers do for their children. This sets up a different level relationship, the general practitioner being in control and telling the patients what to do, just as parents tell their children. Our study reveals that this top-down approach is not only considered normal by the participants, but also seen as appropriate for older patients. Talking like a mother, using warm words and friendly tone of voice is very much valued and triggers trust. The fact that the participants have high trust in the general practitioner is also linked to the long-term relationship, as participants mention that they have been going to the same general practitioner for 10 to 20 years now.

## References

- Adelman, R. D., Greene, M. G., Charont, R. (1991). Issues in physician—elderly patient interaction. *Ageing & Society*, 11(2), 127-148. DOI:10.1017/S0144686X00003974.
- Adelman, R. D., Greene, M. G., Ory, M. G. (2000). Communication between older patients and their physicians. *Clinics in geriatric medicine*, 16(1), 1-24. DOI:10.1016/S0749-0690(05)70004-5.
- Ben-Sira, Z. (1980). Affective and instrumental components in the physician-patient relationship: an additional dimension of interaction theory. *Journal of Health and social Behavior*, 170-180. DOI:10.2307/2136736.
- Britten, N., Stevenson, F. A., Barry, C. A., Barber, N., Bradley, C. P. (2000). Misunderstandings in prescribing decisions in general practice: qualitative study. *Bmj*, 320(7233), 484-488. DOI:10.1136/bmj.320.7233.484.
- Bytheway, B. (2005). Ageism and age categorization. *Journal of social Issues*, 61(2), 361-374. DOI: 10.1111/j.1540-4560.2005.00410.x.
- DiMatteo, M. R., Giordani, P. J., Lepper, H. S., Croghan, T. W. (2002). Patient adherence and medical treatment outcomes a meta-analysis. *Medical care*, 794-811. DOI: 10.1097/01.MLR.0000024612.61915.2D.
- Eurobarometer (2012), Retrived from [http://ec.europa.eu/commfrontoffice/publicopinion/archives/eb/eb77/eb77\\_en.htm](http://ec.europa.eu/commfrontoffice/publicopinion/archives/eb/eb77/eb77_en.htm).
- Greene, M. G., Adelman, R. D. (2003). Physician—older patient communication about cancer. *Patient Education and Counseling*, 50(1), 55-60. DOI:10.1016/S0738-3991(03)00081-8.
- Greene, M. G., Majerovitz, S. D., Adelman, R. D., Rizzo, C. (1994). The Effects of the Presence of a Third Person on the Physician-Older Patient Medical Interview. *Journal of the American Geriatrics Society*, 42(4), 413-419. DOI:10.1111/j.1532-5415.1994.tb07490.x.
- Haskard Zolnierek, K. B. H., DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: a meta-analysis. *Medical care*, 47(8), 826. DOI:10.1097/MLR.0b013e31819a5acc.
- Levinson, W., Lesser, C. S., & Epstein, R. M. (2010). Developing physician communication skills for patient-centered care. *Health affairs*, 29(7), 1310-1318. DOI:10.1377/hlthaff.2009.0450.
- Peck, B. M. (2011). Age-related differences in doctor-patient interaction and patient satisfaction. *Current gerontology and geriatrics research*, 2011. DOI:10.1155/2011/137492.
- Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian Medical Association Journal*, 152(9), 1423. WOS:A1995QV70200023.
- Williams, S. L., Haskard, K. B., DiMatteo, M. R. (2007). The therapeutic effects of the physician-older patient relationship: effective communication with vulnerable older patients. *Clinical interventions in aging*, 2(3), 453. WOS:000208238500019.