

## **UC Davis**

### **UC Davis Previously Published Works**

#### **Title**

"I'm Troubled, Doc!" - Reflections on the Care of Elderly Patients

#### **Permalink**

<https://escholarship.org/uc/item/6034s21m>

#### **Journal**

Clinical Geriatrics, 21(10)

#### **Author**

Milstein, Jay M.

#### **Publication Date**

2013-10-09

#### **Supplemental Material**

<https://escholarship.org/uc/item/6034s21m#supplemental>

Peer reviewed

# “I’m Troubled, Doc!” – Reflections on the Care of Elderly Patients

- Posted: 10/9/2013
- [Volume 21 - Number 10 - October 2013](#)
- 1727 reads
- [Point of View](#)

Citation:

*Clinical Geriatrics*. 2013;21(10). Published online October 9, 2013.

**Author:** Jay M. Milstein, MD

**Affiliations:** Division of Neonatology, Department of Pediatrics, University of California Davis Health System, Sacramento, CA

**Abstract:** As people age, they experience life-altering events, such as serious illnesses, that can create a sense of hopelessness and lead to a loss of meaning in their lives and in the lives of their families. Often, patients and families may find themselves in a state of despair, finding it difficult to cope. Clinicians who provide care to older adults in any care setting can play a critical role in restoring order to devastated patients and families. In this article, the author provides his perspective on creating both empathy and a compassionate presence and describes a methodology for building the cognitive and emotional foundation for a physician–patient relationship and a framework for shared decision-making.

**Key words:** Compassionate care, compassionate presence, empathy, shared decision-making.

Life-altering events interrupt life stories. These events often generate a sense of hopelessness and loss of meaning among patients and their loved ones. Restoring a sense of order to their narratives is essential to reestablish a feeling of wholeness in their lives. Because patients and their families are often in such states of despair, they cannot cope without being provided a compass in their difficult journeys. Creating a compassionate presence that fosters a sense of trust and caring may be critical to helping provide that compass and restoring order for these devastated patients and families. The elderly may be particularly vulnerable to these feelings, as they may not be functioning optimally due to aging, progressive disease processes, or both. In addition, being thrown into unfamiliar territory, such as being hospitalized, institutionalized, or encountering another situation that they have never dealt with before, may add to their confusion. What follows are a few examples that may help clarify the importance of a compassionate presence. The first example is from a professional perspective, whereas the latter two are from a personal perspective while I was on the other side of the examining table.

## Example 1

As an attending neonatologist, I accompanied house officers on rounds conducted with the family present. The house officers systematically reviewed the care of an infant undergoing whole-body hypothermia as an interventional modality for potentially modifying the natural history of hypoxic-ischemic encephalopathy in term neonates. They reviewed each of the physiologic systems to formulate decisions about care. The team answered the family’s questions after completing their discussion, but offered no engaging or compassionate comments. Witnessing this rounding process, I got the impression that the family was likely feeling overwhelmed. I wrote about this case in an article in *Clinical Pediatrics*, in which I described that the “data-dumping format” could be “both frightening and dehumanizing . . . failing to create the warm, supportive environment that new parents and all patients and families so richly deserve.”<sup>1</sup> As the attending physician, I decided “to create a compassionate presence without dwelling on the facts of the case but rather focusing on the parents’ thoughts and feelings as they experienced this ordeal.”<sup>1</sup>

## Example 2

I once rushed to an emergency department at the recommendation of my primary care physician because I was experiencing chest pain. After reviewing my electrocardiogram (EKG), the physician very matter-of-factly examined me. Perhaps there was an element of theatrics, but I exclaimed, “I’m troubled!” Thereafter, the physician provided a more compassionate presence and reviewed the EKG with me, and, most

importantly, engaged in a comforting chat with me, exploring what was troubling me and opening up the human elements to my condition—the illness.<sup>2</sup> It did not assuage my fears; however, it did give me a sense that someone was *listening*. Appropriate follow-up tests and visits were planned, and I had a sense of relief.

### **Example 3**

On another occasion, after experiencing a comminuted fracture that ultimately required pinning as well as a wrist jacket, I was on an exploration again. When I expressed to my orthopedic surgeon, “I’m troubled,” he responded that I was probably feeling a loss of control. From my perspective, he may have addressed the psychological elements of my stress and the avenue that I may be more likely to pursue; however, his response to my on-the-spot test was not bad. Nevertheless, it was not as good as if he had delved into what was truly bothering me. After all, my source of stress could have been more physical and practical, rather than simply attributable to a feeling of “a loss of control.”

### **Creating a Compassionate Presence**

In the first example, the patient was at the beginning of life; however, the lessons learned in my own experiences as described above can be applied to the care provided to patients of all ages. Creating a compassionate presence represents a critical step in facilitating restoration of order, sensemaking (ie, the process by which people give meaning to their experience), and shared decision-making among patients and healthcare providers.

Communication conducted in a caring, empathic manner requires genuinely listening and respecting what is important to the patient. In essence, restoring order requires helping others to examine their life stories and to clarify their goals and values. Beyond shared decision-making paradigms,<sup>3</sup> the rationale for compassionate communication is that it creates the foundation for a relationship built on trust and empathy. This empathy by the caregiver, whether a staff member or a family member, can permeate the relationship with the patient, creating an environment conducive to sensemaking for the patient. It also permits a compassionate presence to coexist at both ends of the shared decision-making continuum, which has at its end points paternalistic, physician-driven decision-making and autonomous, patient-driven decision-making.<sup>3</sup> Furthermore, the compassionate presence creates a relationship that may be invaluable to long-term care, independent of the designated decision-maker. Communication is emphasized in the currently defined continuum<sup>3</sup>; however, the nature of the relationship between the patient and the healthcare provider at both ends of the continuum is not specifically addressed. A caring physician–patient relationship built on trust and compassion provides an environment where there is not a sense of abandonment, even if the patient and/or family were to assume autonomous roles in or along the joint-decision-making continuum. Connection can remain vital to ongoing care, even if decision-making may not be consistent with the physicians’ recommendations, had a paternalistic, physician-driven model been in effect. Ironically, that type of acceptance may foster some shift in the continuum merely because of the trust, empathy, and compassion that is so prominent in the relationship, whether or not that is the goal. Joint decision-making requires recognizing patients’ goals, considering them in alignment with medical realities in choices,<sup>4</sup> and respecting where a particular patient and family fall along the shared decision-making continuum.

When our stories are interrupted by illness and other life-altering events, restoring order may pave a path to sensemaking and healing in patients and their families. In non-life-altering situations, restoring a sense of meaning may simply be addressed in physical, cognitive, and emotional domains. In the presence of life-altering situations, more existential questions may arise. Transcending beyond oneself and one’s physical world and entering a more spiritual domain may be essential to address this interruption.<sup>5</sup> But the process for achieving this level of care is not always easy or obvious. Below, I describe a two-step process for creating a compassionate presence that is based on my experiences working with patients and their family members.<sup>6,7</sup>

### **Methodology**

Development of a compassionate presence can be viewed as a two-step process. The initial step involves development of a compassionate presence—a mindset of empathy—in oneself. The second step involves its development in another.

For healthcare providers working in any patient care setting, the initial step in developing empathy is to assist staff caregiver(s) to develop a relaxed state. This can be achieved using a variety of techniques, including autogenic training (ie, a relaxation technique during which waves of relaxation enter the crown of the head with the breath, generating a sense of warmth and heaviness in the limbs) or mindfulness meditation (ie, a form of meditation in which distracting thoughts and feelings are acknowledged and observed nonjudgmentally as they arise as a means of detaching from them while gaining insight and

awareness).<sup>8</sup> Once the participants are in a relaxed state, the guide will instruct them to gently close their eyes, if comfortable, and then to recall a life-altering experience that they have experienced. To restore order to participants' narratives, the guide will ask them to consider the thoughts, feelings, and physical sensations they experienced both *before* and *after* this life-altering event. These recollections can be verbalized or recorded in a journal after the exercise is completed. A simple prompt, such as bringing an index finger and thumb together, is introduced to return the participant (ie, the healthcare provider) to the same empathic state of mind generated before encountering patients. The recollection of a life-altering event generates a sense of empathy in the participant. The index finger–thumb prompt serves to capture the feelings of empathy generated by the earlier recollection. It is not to go back to the story itself, but just the feeling that the story elicited. This training exercise can be self-taught or developed with a guide.

Upon completion of the aforementioned training exercise, whether with guidance or self-instruction, each healthcare provider/trainee will recall the above state-of-mind using the simple prompt developed to return to an empathic state of mind to be generated when encountering patients. The healthcare provider/trainee will then use the same techniques from the initial step with their patients. After inducing or guiding each subject into a relaxed state, the healthcare provider/trainee will then guide each patient one at a time through an exploration of a life-altering event or the presenting situation. In this process, the patient may feel a sense of value and importance to someone else, even in the face of a life-altering event.<sup>5,9</sup>

Each patient will be guided to consider what his/her life was like *before* then *after* a particular event: what they thought; what they felt; how it resonated to their core; and what physical sensations they may have experienced. This interaction may represent a very engaging, caring step between the healthcare provider and the patient. The patient will then be guided to focus on his or her breath, as this action shifts one's awareness to the present moment. With a perspective of being in the present and with intention, the patient's responses—as opposed to reactions—can be altered in a favorable way if similar events occur in the future. While this may be an exercise, the shift to the present may be very relevant to the patient's ongoing care because once a compassionate presence is established and the patient becomes more trusting, he or she may be better able to respond to any pressing demands and additional stressors over and above the gravity of the underlying life-altering event when the task of making other relevant life-altering decisions confronts him or her. In addition, the shift to the present may help the patient let go and not perpetually ruminate.<sup>10</sup>

### Conclusion

The rationale for proposing this paper as a point of view as opposed to a study is that while the conceptual design of compassionate care may seem simple enough, its methodological execution and assessment are more complex. Care for patients and their families undergoing a life-altering event can be dramatically improved by cultivating a compassionate presence using the approach described in this article. A caring patient–physician relationship built on trust and empathy can be achieved by asking the simple but important question: “what’s most troubling to you?”

### References

1. Milstein JM. Role modeling at the bedside. *Clin Pediatr (Phila)*. 2012;51(4):311-313.
2. Milstein JM. A paradigm of integrative care: healing with curing throughout life, “being with” and “doing to.” *J Perinatol*. 2005;25(9):563-568.
3. Kon AA. The shared decision-making continuum. *JAMA*. 2010;304(8):903-904.
4. Barry MJ, Edgman-Levitan S. Shared decision making—pinnacle of patient-centered care. *N Engl J Med*. 2012;366(9):780-781.
5. Milstein JM. Introducing spirituality in medical care: transition from hopelessness to wholeness. *JAMA*. 2008;299(20):2440-2441.
6. Milstein JM, Gerstenberger AE, Barton S. Healing the caregiver. *J Altern Complement Med*. 2002;8(6):917-920.
7. Milstein JM, Raingruber BJ, Bennett SH, Kon AA, Winn CA, Paterniti DA. Burnout assessment in house officers: evaluation of an intervention to reduce stress. *Med Teach*. 2009;31(4):338-341.
8. Benson H. The relaxation response. In: Goleman D, Gurin J, eds. *Mind/Body Medicine: How to Use Your Mind for Better Health*. Yonkers, NY: Consumer Reports Books; 1993.

9. Frank AW. *The Wounded Storyteller: Body, Illness and Ethics*. Chicago, IL: The University of Chicago Press; 1995.
10. Williams M, Teasdale J, Segal Z, Kabat-Zinn J. *The Mindful Way Through Depression: Freeing Yourself from Chronic Unhappiness*. New York, NY: Guilford Press; 2007.

**Disclosures:** The author reports no relevant financial relationships.

**Address correspondence to:** Jay Milstein, MD; Division of Neonatology, Department of Pediatrics, University of California Davis Health System, Ticon II Room #354, 2516 Stockton Boulevard, Sacramento, CA; [jmmilstein@ucdavis.edu](mailto:jmmilstein@ucdavis.edu).

- See more at: <http://www.clinicalgeriatrics.com/articles/%E2%80%9CI%E2%80%99m-Troubled-Doc%E2%80%9D-%E2%80%93-Reflections-Care-Elderly-Patients#sthash.eAxcik3.dpuf>