What Elders Want:

A Qualitative Meta-synthesis of Elders’ Views on

Interactions with their General Practitioners

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A thesis submitted to the Graduate Program in Cultural Studies

in conformity with the requirements for the

Degree of Master of Arts

Queen’s University

Kingston, Ontario, Canada

September, 2013

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ABSTRACT

Effective communication in the doctor-patient relationship is an essential component to proper diagnosis and treatment (Gordon & Gerber, 2010). While a greater focus on improving doctor-patient communication needs to be addressed, nowhere is it more important than in interactions between geriatric patients and general practitioners. This study analyzes and synthesizes the findings of 16 selected socio-medical journal articles that report on the views of geriatric patients’ needs and desires when interacting with general practitioners. The findings of this study contribute a geriatric perspective to the current debate regarding patient-centred care and also identify communication barriers and facilitators that can be avoided or used by physicians when interacting with geriatric patients. By bringing together multiple socio-medical qualitative studies that look at geriatric patients’ perspectives, this research seeks to create an evidence base that is valued by both medical practitioners and policy-makers.
ACKNOWLEDGEMENTS

This research was supported by funds from Queen’s University as well as an Ontario Graduate Scholarship (2012 – 2013).

Special thanks goes to my supervisor, Dr. Annette Burfoot, and my first reader, Professor Gary Kibbins, both of whom supported my research whole-heartedly.

I want to thank my parents, Jill and Brad Bedford, for always believing in my ability to achieve and succeed (even when I haven’t), and for “forcing” me to pursue a university education in the first place. A thank you goes to my friend Julie Bourassa, who was there for me during all the difficulties and successes with a bottle of wine in hand. And I especially want to thank my wonderful partner, Doug Rotar, for spending countless hours providing me with editing, flash, and emotional support. Without him, I would never have survived my MA with my sanity still intact.
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CHAPTER 1 – INTRODUCTION

Effective communication in the doctor-patient relationship is an essential component to proper diagnosis and treatment (Gordon & Gerber, 2010). Diagnosis, defined by Sanders as “the identification of the patient’s disease” (2009, p. xiv), is the first step in effectively treating a patient’s illness and relies heavily on the patient’s description of their symptoms and disease experience. According to Sanders (2009), anywhere from 70 to 90 percent of accurate diagnoses are made on the basis of the patient’s story alone; despite this, many studies have documented the consistent practice of physicians interrupting patient narratives, which occurs more than 75% of the time, and within less than 20 seconds of the patient beginning their story (Sanders, 2009; Jagosh, Boudreau, Steinert, MacDonald, & Ingram, 2011; Lussier & Richard, 2006; Menz & Al-Roubaie, 2008). As a result, many patient concerns go unvoiced, potentially hindering the ability of the doctor to make an accurate diagnosis. Sanders (2009) indicates that this is a widespread problem, with between 10-15 per cent of patients in the United States alone receiving inaccurate diagnoses, 17 per cent of which result in adverse outcomes for the patient.

While a greater focus on improving doctor-patient communication clearly needs to be addressed, nowhere is it more important than in interactions between geriatric patients and general practitioners. Currently, the population of seniors, “individuals aged 65 and over”, is projected to increase from 4.2 million to 9.8 million over the next three decades (Turcotte & Schellenberg, 2007, p.12). By 2056, Canada’s ratio of seniors will be 1 in 4 (Gates et al., 2009). With the proclivity of geriatric patients to be less willing to actively participate during the doctor-patient interaction (Strauss & Tinetti, 2009), mastery of communication skills, and in particular, communication skills geared toward working with the geriatric patient, will be
essential for all general practitioners, especially with regard to the wider cultural and social factors involved.

**Purpose of Study**

This study analyzes and synthesizes the findings of 16 selected socio-medical journal articles that report on the views of geriatric patients’ needs, desires, tips, and pointers when interacting with general practitioners. The information derived from these articles is contextualized and supported with further research on: the history of the doctor-patient relationship, the current medical context within which physicians practice, the natural aging process (e.g. signs and symptoms of hearing loss) experienced by geriatric patients, the three main theoretical models of doctor-patient communication, and current educational practices used in North American and Euro-Western medical schools.

The paper will begin by discussing the socio-historical context that has shaped the doctor-patient relationship experienced today, followed by a brief description of the medical context that currently influences these relationships. The paper will then outline the basic characteristics of the geriatric patients that physicians and physicians-in-training will encounter over the next decade. Next the paper will discuss geriatric content and the use of communication skills training in medical schools. Within this section, the paper will outline the three main theoretical models of doctor-patient interaction and will demonstrate the importance of good doctor-patient communication with particular consideration for communication with geriatric patients. Finally, a brief literature review will situate my research, and the importance thereof, in the greater dialogue regarding patient-centred communication (with geriatric patients in particular) and communication skills training.
Overall, the goal of this research is to identify communication techniques and strategies that will be integrated into an interactive training module designed to teach undergraduate school of medicine students how to better communicate with their geriatric patients.
CHAPTER 2 – CONTEXT AND REVIEW OF LITERATURE

Socio-Historical Context

The doctor-patient relationship has been a fluid and changing one that has developed over a long period of time. The pre-1700s marked a strong adherence to spiritual and religious beliefs, and because medicine and the functioning of the body were not well understood nor institutionalized as it is today, the doctor was seen as someone filled with magical powers (Potter & McKinlay, 2005; Kaba & Sooriakumaran, 2007). Regardless of the high mortality rates, short life expectancy, and the inadequacy of many medical practices (Brosco, 2004), the doctor retained authority over the patients for whom they cared, establishing a largely paternalistic relationship similar to that of priests and members of their parish.

Enter the 18th century, Age of Enlightenment and the industrial revolution. Fuelled by the rise of empiricism in the 1600s, medicine began to make ground as a social authority, and reliance on scientific explanations of life, as opposed to religious explanations, became increasingly common. The Age of Enlightenment saw the invention of vaccines and the development of germ theory to explain disease and illness (Brosco, 2004). Sanitation became a major contributor to the practical and effective practice of medicine as well. Due to medical inventions, cleanliness, the increasing ease of production, and increasing access to a diverse array of inexpensive products, daily existence became easier and the average person’s life expectancy was greatly increased.

Though an interest in the services provided by medical professionals began to rise during this time, relatively few people were trained as doctors, leaving a large discrepancy between the number of patients in need or desirous of medical services, and the number of trained medical professionals available to provide them. In addition to the lack of trained doctors, the
Enlightenment fuelled ideas of independence, freedom, and liberty within the general populace, effectively altering the revered position doctors held in pre-1700 society (Crawford, 2006). With rudimentary medical knowledge such as the emphasis on sanitation slowly becoming accessible to the general populace, and science and reason replacing spiritual and magical beliefs, society no longer thought of doctors as possessors of magical powers. As a result, power dynamics within the doctor-patient relationship shifted.

Other cultural factors that served to enhance the growth of patient power included the fact that, at the start of the 1700s, patients were still treated in the home. Since friends and family members were generally present during the doctor’s visits, they often contributed to the decision-making regarding diagnosis and treatment, at times even directly contradicting the doctor’s recommendations (Wilde, 2007). As well, the sheer distance between patients’ residences and the minimal number of available physicians to attend to a growing number of patients often meant that doctors were not able to see a patient until several hours, or even several days after their presence was requested; this meant that the responsibility for treating the illness fell to the family, local midwives or healers, and the sick individual themselves. Since the doctor was unable to be a consistent and reliable source of healthcare information, their authority over patients was diminished in favour of the treatment experience gained by family members, local midwives and healers, and the patients themselves. Finally, physician authority was also diminished due to the patients for whom physicians cared: Their main clients were members of the nobility and the wealthy elite (Crawford, 2006). As reputation was the chief means by which doctors remained in business, pleasing their clients became more important than asserting their authority (Kaba & Sooriakumaran, 2007). Thus patients retained far greater power within the doctor-patient interaction.
The development of the biomedical model of medicine during the 1800s was one of the most important developments for modern medicine, as well as one of the most significant determinants of the raised status of physicians within society. With the biomedical model came the use of technologies such as stethoscopes and thermometers that privileged the physician-controlled examination of the patient over the patient narrative (Wilde, 2007).

The rise of hospitals beginning in the late 1700s also impacted the doctor-patient relationship, slowly moving the realm of the doctor-patient interaction away from the patient’s home and to the doctor’s territory (Brosco, 2004; Wilde, 2007). Though among the elite doctors continued to suffer from medical powerlessness (Wilde, 2007), the type of clientele that frequented hospitals, namely those of lower classes who were more passive when interacting with authority figures, meant that doctors were able to assert medical authority over their patients (Kaba & Sooriakumaran, 2007); this lead to a resurgence of the paternalistic model of interaction.

By the end of the 1800s, the biomedical model was entrenched in society through the professionalization of medicine and the requirement that all physicians receive formal training (Will, 2011a). In America alone, more than 130 medical schools opened to train doctors (Will, 2011a). Due to the necessity for medical training, lay-people had to finally resign themselves completely to medical authority.

The 1900s saw the start of what is known as “the Golden Age of Medicine” (Crawford, 2006). The medical profession began to thrive. Since the demand for doctors outstripped supply, doctors gained a monopoly over the healthcare economy. While doctors still provided services to the general population through hospitals, they no longer made house calls, instead moving to private practices and requiring patients to come to them (Wilde, 2007).
Many governments in developed countries took note of this monopoly and began to invest in healthcare, both by funding the provision of healthcare access for the populace as a whole, as well as through the funding of medical schools to encourage the training of larger numbers of medical professionals (Potter & McKinlay, 2005). World War I and II served to increase the demand for the training of medical professionals. According to Benoit, Zadoroznyj, Hallgrimsdottir, Treloar & Taylor (2010), the 1940s especially saw a huge increase in government spending on medicine geared towards improving public healthcare. This increase in spending enhanced the medical authority of doctors by providing them with unchallenged state support (Benoit et al, 2010). As a result, doctor-centred medical practice was common (Hildebrand, 2007) and largely uncontested.

As psychoanalysis began to gain popularity in the 1950s, the interactions between doctors and patients in every-day medical encounters started to favour patient narratives once again. The emphasis on therapeutic methods used by psychologists and psychoanalysts, such as asking open-ended questions and listening, began to transfer to other parts of medicine as well (Kaba & Sooriakumaran, 2007; Hildebrand, 2007).

Civil rights movements advocating for citizen rights in the political sphere also played a role in altering people’s attitudes towards authority. The civil rights movement of the 1950s-1980s caused social movement spill-over to occur (Epstein, 1996), encouraging the emergence of the patients’ rights movement, and the women’s health movement in the 1970s, both of which emphasized the idea of patient-centred healthcare (Hildebrand, 2007). These movements significantly impacted the doctor-patient relationship by undermining medical authority in favour of patient autonomy, and by further shifting the patient role to that of a consumer.
From the 1970s onward, the number of malpractice lawsuits being filed increased exponentially, forcing the creation of the Informed Consent Doctrine in the United States of America, which required that, “patients be given the right to consent to or refuse healthcare and that they be provided with all information material to a decision to consent to or to refuse healthcare” ([emphasis in original] Dolgin, 2010, p.99). With societal values transitioning the doctor-patient relationship from one similar to the relationship shared by family members and characterized by trust, loyalty and grounded relationships (Dolgin, 2010) to one characterized by hyper-individualization and autonomy, the consumer patient emerged, complete with an expectation to consume medical services to which they felt entitled (Potter & McKinlay, 2005).

**Current Canadian Context**

The context within which physicians and the healthcare system operate continues to influence the doctor-patient relationship, particularly with respect to geriatric patients. In Canada, the healthcare system functions within a semi-private, semi-public context. While many see the Canadian system as a publically-funded healthcare system, Health Canada defines it as a medicare system, which is a publicly-funded insurance program (Health Canada, 2011). As an insurance program, payment for most basic medical services is transferred to a publicly-owned insurance agency that is funded through taxes (Anonymous, 2005). According to Health Canada, the healthcare insurance plan “is designed to ensure that all residents of Canada have reasonable access to medically necessary hospital and physician services on a prepaid basis, and on uniform terms and conditions” (Health Canada, 2011).

While the healthcare system is partially funded by the Federal government, the majority of services are administered by each individual province and territory, which results in different service coverage across the country (Légaré, Stacey, Forest & Coutu, 2011). The *Canadian*
*Health Act* requires that provinces publically insure hospital services (for both in- and out-patients); services that are medically necessary for maintaining health, preventing disease, or diagnosing and treating injury, illness, or disability; and medically-required physician services (Health Canada, 2011). Many other services such as dental care or eye care are not publically-funded (Anonymous, 2005).

In the case of seniors, provinces generally provide coverage or partial coverage for certain amenities. In Ontario for instance, the Ontario Health Insurance Program (OHIP) provides health coverage to seniors for one eye exam per year (OHIP, 2005b). As previously stated however, coverage differs by province, and in many cases, only provides access to medically-necessary services. For example, dental services, excluding medically-necessary surgery provided in hospital, are not covered by OHIP despite the role that dental integrity can play in helping seniors maintain adequate nutrition levels.

The two-tiered healthcare system in Canada inevitably serves to generate inequalities in healthcare delivery (Anonymous, 2005). Canada currently faces a shortage of doctors, particularly in rural areas and northern communities. The lack of physicians directly impacts wait times and consultation times, encouraging physicians to emphasize the need for patients to present only one problem per visit (Frank, 2010). As a system that focuses primarily on acute as opposed to preventative or chronic care (Kane, 2007), the one-problem-per-visit mantra does not significantly impede healthcare delivery for younger patients; however, it does not allow for efficient or effective care for geriatric patients who often suffer from multiple, complicated and inter-influential chronic conditions. Unfortunately, billing codes are not very flexible, preventing physicians from being able to accommodate longer, more interdisciplinary visits (Frank, 2010).
Though patients frequently complain that medical consultations are too short (Lussier & Richard, 2006), consultation times have actually increased from an average of 16 minutes in 1989 to 22 minutes in 2009 (Sanders, 2009). In response to the perceived time crunch, however, doctors often resort to paternalistic methods of doctor-patient interaction, spending more time reviewing patient history than focusing on the presenting problem (Potter & McKinlay, 2005) and using targeted questions that can inhibit patient participation and increase the chance of miscommunication and misdiagnosis (Roter, 2000; Sanders, 2009). Also notable is the lack of time spent on discussing socio-emotional aspects of care—aspects that can be very important to a geriatric patient’s quality of life (Roter, 2000).

Due to an increasing number of interdisciplinary healthcare centres (Reuben & Rosen, 2009), geriatric patients can also suffer from lack of continuity of care. Continuity of care for patients with chronic illnesses helps patients feel in control of their illness, prevents them from using hospital services as often, and allows doctors to know when treatment changes are needed (Potter & McKinlay, 2005). A lack of continuity can mean a greater number of hospital visits for elderly patients, or even an inability to continue to live independently.

Finally, interventions by the state and other institutions, which occur frequently in the United States, can pressure physicians to cut costs and distribute resources evenly. This pressure often translates to shorter doctor visits, fewer referrals (Hellín, 2002; Potter & McKinlay, 2005) and even health care rationing based on patient age (Mueller, Hook & Fleming, 2004).

A Portrait of the Geriatric Patient

In the 1920s and 1930s, seniors accounted for approximately 5% of the Canadian population (Turcotte & Schellenberg, 2007). Since then, life expectancy has increased dramatically. Today seniors comprise around 13-14% of the population, more than 4000 of
which are centenarians (i.e. seniors 100 years of age or older) (Turcotte & Schellenberg, 2007; Frank, 2010). Though most of Canada’s senior population is concentrated in Ontario and Quebec, which is largely due to the fact that these provinces are the most populous, it is the Atlantic Provinces that are projected to see the largest increase of seniors in the near and distant future (Turcotte & Schellenberg, 2007).

Many of the seniors coming of age today are World War II baby boomers. These individuals are very diverse, having experienced backgrounds, lifestyles, and upbringings that were very different from those of their parents (Roter, 2000), ultimately altering the ways in which they view doctor-patient interactions. Since women usually live longer than men, women make up the majority of seniors over the age of 80. Despite their longevity, women more often suffer from worse health and higher rates of disability (Guralnik & Ferrucci, 2009).

**Chronic Conditions**

Treating geriatric patients can be very complicated. Disease presents differently in older adults than in younger patients due to multiple and compounding problems, which make new diseases hard to identify (Adelman, Greene, & Ory, 2000; Kane, 2007; Strauss & Tinetti, 2009). In addition, many signs and symptoms experienced by geriatric patients are the result of the stress that illness can put on aging bodies, and not necessarily a symptom of the illness itself (Kane, 2007). Many seniors suffer from comorbidity, which is the presence of multiple chronic conditions (Canadian Institute for Health Information, 2011). Hingle and Robinson report that “for every decade of life after age 40, patients are likely to have 1 new chronic disease” (2009, p.1). The more chronic conditions a senior has, the more they make use of health services. This use is NOT dependant on age; a report by the Canadian Institute for Health Information on geriatric healthcare use found that “total health care use increased with the number of reported
chronic conditions across all senior age groups.” (2011, p.8) therefore, healthcare use among seniors is more dependent on the presence of chronic conditions than on a senior’s age (Canadian Institute for Health Information, 2011).

The most frequently reported chronic conditions experienced by seniors in Canada include high blood pressure, arthritis, heart disease, and diabetes (Canadian Institute for Health Information, 2011). When seniors suffer from multiple conditions, they are most likely to experience the following chronic condition combinations: high blood pressure and arthritis; high blood pressure and heart disease; high blood pressure and diabetes; heart disease and arthritis; and high blood pressure and cancer (Canadian Institute for Health Information, 2011). Other conditions that impact seniors’ activities of daily living (ADLs), i.e. self-care tasks (Guralnik & Ferrucci, 2009), or their instrumental ADLs, “tasks that are physically and cognitively somewhat more complicated and difficult than self-care tasks and are necessary for independent living in the community” (Guralnik & Ferrucci, 2009, p.10), include: balance and mobility problems; weight issues [in North American community-dwelling adults, weight is usually too high (Reuben & Rosen, 2009), however seniors also suffer from malnutrition and extensive weight loss]; sensory loss (discussed below); incontinence, which is more common in women; and sexual difficulty, which is more common in men.

For many reasons, the existence of chronic conditions can have a huge impact on healthcare spending. According to a study conducted in 2000 by the Public Health Agency of Canada, the total burden of cardiovascular healthcare spending alone was $22.2billion (Canadian Institute for Health Information, 2011). Currently, seniors account for approximately 44% of public healthcare costs. When their chronic conditions are not well managed, seniors make greater use of hospitals. With hospitals responsible for the majority of Canada’s healthcare costs,
accounting for “more than 70% of the total public and private health spending in 2001” (Chenier, 2004, p.7), it is clear that seniors have the potential to directly impact our healthcare system through such things as hospital use. Finding ways to improve geriatric care is therefore essential.

**Prescription Drug Complications**

According to Rochon, Tjia, Gill and Gurwitz (2009), there are four types of prescribing problems that can occur within any medical encounter; these include the use of inappropriate dosages, duplication of therapies by more than one healthcare provider, neglecting to predict potential drug interactions, and inappropriate duration of prescribed therapies. Further complicating these issues is the fact that seniors are often excluded from drug trials; determining appropriate drug therapies can therefore be very difficult (Rochon et al., 2009). As well, the more conditions from which a senior suffers, the more medications they are prescribed. Seniors who suffer from three or more health conditions take an average of six different prescription medications—double that of a senior suffering from only one health condition (Canadian Institute of Health Information, 2011).

The use of five or more medications is known as polypharmacy. Polypharmacy is associated with adverse drug reactions (ADRs), reduced adherence, and inappropriate medication usage (Reuben & Rosen, 2009). Approximately 28% of hospital admissions in the United States are caused by drug-related problems, over 70% of which are attributed to ADRs (Rochon et al., 2009). Despite the fact that the more prescription medications a senior is on, the more likely they are to suffer from ADRs, seniors on multiple medications are less likely to receive drug and side effect information from their physicians (Canadian Institute for Health Information, 2011); as well, very few have their medications reviewed by a doctor.
Prescription-related complications can be the result of the four types of prescribing problems indicated above, however, they can also occur as the result of failed or inadequate communication between a doctor and their geriatric patient. Studies have shown that patient recall for complex medical regimens is especially difficult (Stewart, Meredith, Brown & Galajda, 2000). More information about the purpose and use of medications has been shown to improve adherence among older adults (Stewart et al., 2000). In addition, the more a physician understands their patient’s personal context, the more they will be able to work with the patient to develop a clear and mutual treatment plan that will help improve patient adherence.

**Sensory Loss**

Communication is very important for sharing information, building relationships, and understanding the behaviour of others, especially within the clinical encounter. When older adults experience sensory loss, communication breakdown occurs more often; this can have a profound impact on a senior’s quality of life. Research demonstrates that seniors with sensory loss are more likely to withdraw from communication situations and that they often feel vulnerable, depressed, insecure, exhausted, and unable to adjust to their sensory loss (Heine & Browning, 2004).

Natural aging often presents with the following sensory losses:

**Presbycusis**

Presbycusis occurs when a person experiences a decreased ability to hear higher frequency sounds (Adelman et al., 2000). Presbycusis is the most common type of hearing loss, and for seniors, it is the most common sensory change they will experience as they age. Audiological evaluations of older adults have demonstrated that hearing loss is experienced by up to 50% of adults aged 50+ and up to 90% of adults aged 80+ (Fowler & Leigh-Paffenroth,
Despite these percentages, studies show that only around 20% of older adults with hearing impairment wear hearing aids (Clark-Cotton, Williams, Goral & Obler, 2007; Fowler & Leigh-Paffenroth, 2007). Men, more often than women, experience greater levels of hearing loss at an earlier age, usually reporting it during their mid-60s; however, around age 70, women and men suffer from hearing loss more equally (Fowler & Leigh-Paffenroth, 2007).

Impaired hearing can have a profound impact on a senior’s ability to communicate. Research demonstrates that even a minor loss of hearing can be associated with a reduction in cognition and working short-term memory (Fowler & Leigh-Paffenroth, 2007). Hearing loss can also cause seniors to withdraw from communication, or employ coping strategies that hide their hearing loss, such as pretending to understand a communication partner (Wallhagen & Pettengill, 2008).

In the healthcare context, providers must be aware of hearing loss in their patients. According to a study conducted by Wallhagen & Pettengill (2008), 85% of the seniors surveyed by the researchers had not been asked or screened for hearing loss unless they had asked about screening themselves. The study demonstrated that this lack of screening occurred regardless of the patient’s level of hearing loss. Further qualitative inquiry revealed that sometimes physicians completely disregarded hearing impairment. This disregard or lack of concern can have serious health consequences for seniors who experience hearing impairment since failing to recognize and accommodate hearing loss for patients can lead to miscommunication, misdiagnoses, and increased stress (Wallhagen & Pettengill, 2008).

**Vision Loss**

Often, due to natural aging processes, adults age 65 or older experience “a decrease in visual acuity, contrast sensitivity, glare intolerance, and visual fields” (Adelman et al., 2000,
p.5). Many seniors also experience major vision loss, which can be caused by cataracts (lens opacities that affect vision), or age-related diseases such as glaucoma, macular degeneration, or diabetic retinopathy.

Decreased vision has both direct and indirect impacts on communication. Directly, vision loss impairs communication by preventing sufferers from easily reading non-verbal cues, and by compromising their ability to read and write (Clark-Cotton et al., 2007). Vision loss is associated with functional and cognitive decline, indirectly impacting communication abilities. It is also associated with an increased risk of falls, immobility, and depression (Reuben & Rosen, 2009), all of which can indirectly impact communication through decreased communicative abilities and decreased communication opportunities.

**Cognition**

While aging generally comes hand-in-hand with a decline in processing speed, working memory, executive function [i.e. “The set of cognitive skills…that allow a person to successfully plan and execute a task” (Clark-Cotton et al., 2007, p.6)], and attention-span, all of which make language tasks more difficult (Clark-Cotton et al., 2007), longitudinal studies have demonstrated that older adults do not experience much change in their verbal intelligence. This intelligence can be affected (or can appear to change) as a result of declines in motor and processing speed; however, forgetfulness, and severe memory loss as seen with such diseases as dementia and Alzheimer’s, is NOT part of normal aging (Galvin, 2009). In fact, older adults can continue to learn for as long as they remain cognitively healthy, and many continue to show increases in vocabulary, narrative and social skills, and world knowledge and experience (Small, 2007).

In some cases though, seniors can display signs and symptoms of serious cognitive decline. While these signs and symptoms can point to potential depression, which can include the
patient feeling increased anxiety, fearfulness, irritability, cognitive impairment, apathy, and dependency, they can also indicate a cognitive illness, the most common of which are dementia and Alzheimer’s. Dementia is “an acquired disorder of cognitive and self-management abilities, characterized in many instances by progressive decline of intellectual function involving impairment of memory, judgment, and abstract thinking, as well as changes in personality” (Goral, Clark-Cotton, & Albert, 2007, p.17).

Dementia of the Alzheimer type, also known as Alzheimer’s in its more progressed stages, is more recognizable by the barrier to communication that patients face as opposed to general forgetfulness and cognitive decline. When patients with dementia of the Alzheimer type attempt to communicate, they are able to create accurate and intelligible sounds, words, phrases, etc., however the meaning of these combinations is distorted and often does not make sense. These patients also have a difficult time retrieving words (Clark-Cotton et al., 2007).

In the clinical encounter, cognitive decline of any type can impact the communication process.

**Other Socio-Cultural Geriatric Characteristics**

**Literacy**

According to Vandenberg (2001), differences in class and sociolinguistic components within the doctor-patient relationship can be causes for communication failures between patient and doctor. Literacy is a key component of an individual’s sociolinguistic capabilities and can play a major role in patient communication and understanding during the doctor-patient interaction. Often, low-literacy is difficult to detect, however, studies have shown that unrecognized low literacy can result in unfavourable health and health services outcomes (Wolff & Roter, 2008). While patients “with a higher education are apt to receive more information
during the medical encounter” (Vandenberg, 2001, p.21), low literacy reduces a patient’s ability to convey health-related descriptions and is also related to a person’s ability (or lack thereof) to understand verbal communication (Roter, 2000).

A National Adult Literacy Survey conducted in the United States reported that almost half of adults age 65+ could not read at even a basic level (Roter, 2000). Though this statistic is not necessarily representative of North American or Western-European populations, it does shed light on the potential for North American and Western-European physicians to encounter geriatric patients with low literacy levels.

**Religion/Spirituality**

Unsurprisingly, spirituality (whether religious or non-religious) has been found to have an important influence on health (Reuben & Rosen, 2009). At times, spirituality can help patients with the healing process; at others, spiritual beliefs can cause patients to refrain from using healthcare services (Reuben & Rosen, 2009).

In 2001, Statistics Canada published their Canadian Community Health Survey findings. This study assessed the overall health of the Canadian community, but also revealed that many Canadians state that their spiritual beliefs help them find meaning in life, help them face difficulties with strength, or help them understand their difficulties in life (Turcotte & Schellenberg, 2007). In other words, spiritual and/or religious beliefs were important to many Canadians. This finding is important with regard to interactions between physicians and geriatric patients since many seniors were raised with some form of spiritual belief.

**Passivity**

Passivity within the medical encounter is a trait that is often attributed to geriatric patients. In many studies, older patients have been found to ask fewer questions, interrupt less
often, give more socially desirable responses, show more gratitude, and are less likely to express complaints than younger patients (Stewart et al., 2000; Hildebrand, 2007; Strauss & Tinetti, 2009; Gordon & Gerber, 2010; Vandenbergs, 2001).

There are many possible explanations for the passivity displayed by geriatric patients. The most cited is that most geriatric patients today were raised during the “Golden Age of Medicine” (Crawford, 2006), when doctors retained significant power within the doctor-patient relationship. As a result, it is assumed that geriatric patients more often prefer a paternalistic relationship with their physician—one in which the doctor asks questions and prescribes treatments and the patient simply obeys. In fact, some research has demonstrated that elderly patients become uncomfortable when they need to ask questions during medical encounters (Stewart et al., 2000); they frequently have a “don’t ask, don’t tell” relationship with health care providers” (National Institute on Aging, 2008, p.23), especially regarding sensitive subjects such as such urinary incontinence or sexuality. Along the same vein, researchers have found that elderly patients are unlikely to raise the topic that is of utmost concern to them during an encounter with their physician (Vandenberg, 2001) and others confirm that the perception of the doctor as an authority figure can be a deterrent to active patient participation (Gordon & Gerber, 2010).

Despite this research, there are other potential reasons for geriatric patient passivity. For example, while there seems to be a correlation between age and dependency on physicians (i.e. preference for a paternalist style), this preference is also correlated for patients with lower income, lower levels of occupation, and higher illness severity (Roter, 2000). As well, research demonstrates that the sicker a patient is, the more they are likely to prefer a paternalistic doctor (Ong, de Haes, Hoos & Lammes, 1995).
The attitude of the physician can also impact the patient’s willingness to participate. When patients feel that they do not and cannot understand or influence their medical condition, they can become more passive (Gordon & Gerber, 2010). Their belief in their own personal power can be facilitated by physician behaviours that reinforce patient self-confidence, motivation, and a positive view of their health status. On the other hand, physician behaviours such as interrupting the patient, asking close-ended questions, and failing to listen can cause patients to feel unvalued and lacking in personal power over their illness. Because communication is dynamic, both patient and physician can influence each other, with the physician being capable of actively involving the patient and the patient being capable of encouraging the physician to provide more information (Gordon & Gerber, 2010). The more positive but also honest and accurate the physician is, the more positive the patient’s outlook will be (Stewart et al., 2000).

Overall, it is important to remember that all patients are diverse. As Vandenberg (2001) points out, “the Swing generation, those born between 1933 and 1945, appears more knowledgeable about medicine. They ask more questions and demand more answers of physicians…” (p.100). Roter (2000) also confirms the idea that patients are diverse, indicating that post WWII baby boomers have been raised with very different backgrounds and experiences, and therefore have different attitudes towards participation in the doctor-patient encounter. While patient passivity may be a characteristic of some geriatric patients, painting the whole demographic with the same brush is unwise.

**Companions**

Anywhere between 20-50% of geriatric patients are accompanied by a companion during medical visits (Clayman, Roter, Wissow & Bandeen-Roche, 2005). In general, these companions
are either the patient’s spouse, or an adult child (Wolff & Roter, 2008). Having a third person involved in the medical interview can serve to complicate things. There is some evidence that suggests patients become more passive and less involved in decision-making when a companion is present (Clayman et al., 2005). Other research shows that the presence of companions is beneficial to the patient, resulting in more information regarding diagnosis and treatment, and higher levels of patient satisfaction (Clayman et al., 2005; Wolff & Roter, 2008).

The presence of a companion also creates a grey area when it comes to patient privacy; sometimes patients become reluctant to discuss intimate issues when a companion is present. As well, there exists the potential for physicians and companions to mistakenly assume that patients have delegated their decision-making authority to the companion (Clayman et al., 2005).

The presence of companions is a growing occurrence within doctor-geriatric patient interactions and can present interesting challenges for all three parties involved; it is therefore an important factor that physicians must consider when working with geriatric patients.

**Medical Schools**

As of 2011, fewer than 9,000 medical professionals were certified in geriatric medicine in the United States, however, there were over 40 million seniors aged 65+ (Besdine, Shield, McNicoll, Campbell & Wetle, 2011). Similarly, in Canada, there are fewer than 200 physicians with Care of Elderly (COE) training (Frank, 2010). These low numbers have various causes, including low interest in medical specializations in geriatric care, a dearth of medical school faculty trained to teach geriatric care, and a lack of incentive since departments of family medicine do not usually put a focus on hiring doctors with COE training (Frank, 2010).

Already-practicing physicians also face barriers to COE training, such as human resources shortages that prevent them from getting time away from work, or the requirement to
pay for retesting after leaving medical service for too long (Frank, 2010). While there is evidence that medical schools in particular are attempting to encourage more doctors-in-training to pursue a specialization in geriatric care, what is currently necessary due to the rapidly growing geriatric demographic is the training of all physicians in geriatric care.

**Geriatric content**

At the moment, many medical schools in Western-Europe and North America lack a sufficient amount of geriatric content in their medical curricula. In a continent-wide study on geriatric education in Europe conducted in 2006, the researchers found that, of the 17 Western-European countries surveyed, in which 221 medical schools were established, 16 offered geriatrics content in at least one medical school in each nation. However, only seven countries taught geriatrics in every single medical school in the nation (Michel, Huber & Cruz-Jentoft, 2008, p.1538). The study also found that only two schools out of 221 taught core competencies based on those recommended by the European Union, and that “the mean number of undergraduate teaching hours devoted to geriatrics varie[d], with a maximum of 100 hours of teaching in Norway to less than 10 hours in Ireland [and] Luxembourg” (Michel et al., 2008, p.1539).

In the United States, there are over 125 fully accredited medical schools (Liaison Committee on Medical Education, 2013). In 2000, 89% of these schools began to require that medical students be exposed to geriatrics content; however, this “exposure” was not quantifiable nor was it the same across the nation (Hamrick, Kennedy-Malone & Barba, 2008, p.383). Though nursing and pharmacy studies have built geriatrics care training into their programs as a matter of priority, most schools in the United States do not have a department of geriatric medicine, merely seeing geriatrics as a subspecialty (Nussbaum & Fisher, 2009). An Association
of American Medical Colleges (AAMC) review of 40 schools that received funding under the AAMC/Hartford Geriatric Curriculum Program confirmed this lack of geriatrics content provision, indicating that only one third of these 40 schools were striving to include concepts and current practices of geriatrics in their curricula (Anderson, 2004).

Canada’s geriatrics content provision is not much better. In 2005, the Medical Education Committee of the Canadian Geriatrics Society (CGS) developed core competencies in geriatric care that were designed to be included in the curricula of all 17 medical schools across Canada (Parmar, 2009). Though these competencies were submitted in 2008 to the Committee on the Accreditation of Canadian Medical Schools/Liaison Committee on Medical Education, to the Medical Council of Canada, and to the directors of all 17 medical school programs, the competencies have yet to be approved for integration into Canadian medical school curricula (Monette, 2012). Thus, in terms of the geriatric content taught, there continues to be a lot of variability (Frank, 2010).

A survey conducted in 2008-2009 of geriatrics content in Canadian medical schools confirms this spotty and variable geriatrics exposure, demonstrating that, while all 16 of the 17 medical schools in Canada surveyed have geriatrics content in the preclinical years, the number of hours devoted to this content ranges “from 4 to 49 with a mean and median of 21” (Gordon, 2011, p.35). Added to the clerkship rotations required by only seven of the 16 schools, and assuming each clerkship is approximately 40 hours, “the total mandatory hours of geriatrics teaching ranged between 10 and 299 with a mean of 82 hours and a median of 37” (Gordon, 2011, p.35). In comparison to a 2004-2005 survey on Canadian medical school exposure to geriatrics, the number of hours devoted to geriatrics content has increased; however, the content
and the number of teaching hours continue to remain inconsistent across the country (Gordon, 2011).

There are also differences in opinion regarding whether integrated curricula or stand-alone courses are more effective in conveying subject material (Hirst, Lane, & Stares, 2012). One survey conducted in the UK found that teaching geriatrics as a separate course (or program) was favoured (O’Neill & Holland, 2005) whereas other research demonstrates the effectiveness of weaving geriatrics content throughout all medical school courses for normalizing geriatrics as a learning subject (Anderson, 2004; Besdine et al., 2011). A study analyzing the geriatrics curriculum at the Warren Alpert Medical School of Brown University found that integrating geriatrics content into all parts of the curriculum enhanced students’ ability to understand and develop skills for working with geriatric patients (Besdine et al., 2011).

One thing that many researchers seem to agree on is the importance of timing in the introduction of geriatrics content: The earlier the better they say, suggesting that content should be introduced to first year students and continue to be taught throughout medical school (Adelman, Capello, LoFaso, Greene, Konopasek & Marzuk, 2007; Anderson, 2004; Shue & Arnold, 2009). Another study also stresses the importance of incorporating communication skills training for working with geriatric patients as there is currently a dearth of this type of training when geriatrics content is present (Kelly et al., 2012).

**Communications training strategies**

As early as the 1970s, “clinical competence included only three items: medical technical knowledge, physical examination, and medical problem solving” (Kurtz, 2002, p.S23). The current emphasis on communication skills training is recent, though not unjustified. Communication skills are invaluable for the general practitioner, who is estimated to conduct
between 120,000 and 160,000 medical interviews over the course of their career (Brown, 2008). Communication skills are used for taking patient history; explaining information, procedures, etc.; exploring patient illnesses; discussing informed consent; breaking news; negotiating treatment plans; passing on accurate information to colleagues; and presenting case histories (Brown, 2008).

While many doctors and doctors-in-training are apt to consider communication skills innate (Kurtz, 2002), research has found that “doctors who [have] not undertaken communication skills training [have been] unable to demonstrate important basic communication skills, even after 10 years or more of post-registration clinical work” (Brown, 2008, p.271). Studies have also demonstrated the importance of ongoing communication skills training (Street, Gordon & Haidet, 2007), showing that the longer students continue through residency, the worse their communication skills are rated by patients (Al Odhayani & Ratnapalan, 2011). As they say, practice makes perfect and many researchers recommend ongoing professional communication training throughout doctors’ entire career (Kelly et al., 2012; Dawson, 2012; Gruber & Frugone, 2011).

According to the National Institute on Aging (2008), communication training improves medical students’ abilities to communicate, build relationships, manage time, and assess patients (National Institute on Aging, 2008). There are many different ways of teaching communication skills. Traditional communication skills training used to mean observing teachers and preceptors and receiving active coaching in family medicine settings; however, research has demonstrated that these methods inspire little change in learner behaviour (Al Odhayani & Ratnapalan, 2011). Other methods include teaching communication skills in workshops with simulated practice sessions; videotaping medical students during practice consultations and allowing students to
watch and assess their communication skills along with instructors or other classmates (Hildebrand, 2007); interviewing real patients or trained actors who provide feedback to students following the interview; and group work, which has been shown to enhance knowledge and skill retention (Al Odhayani & Ratnapalan, 2011). Many advocate for the inclusion of interactive exercises in communication training courses, emphasizing activities like role-playing, which “has been shown to be effective in enhancing communication skills” (Al Odhayani & Ratnapalan, 2011, p.1217; Sutin, Rolita, Yeboah, Taffel & Zabar, 2011; Shue & Arnold, 2009; Anderson, 2004; Gruber & Frugone, 2011).

Somewhat new to communication skills training within medical schools is the use of electronic learning. Electronic learning is meant to enhance, not replace, the student’s learning experience and is useful for extending learning and training beyond specific course times and places (Al Odhayani & Ratnapalan, 2011). Virtual patients (VPs), which are “case-based computer programs that simulate real-life clinical scenarios” allowing students to practice diagnosing and recommending treatment plans (Tan, Mulhausen, Smith & Ruiz, 2010 p.164), are one method of electronic learning. VPs allow students to gain exposure to multiple medical cases and can potentially assist trainees with their data-gathering and clinical reasoning skills. While current VP use for geriatric education is not widespread, VPs are increasingly being integrated into American and Canadian medical school curricula (Tan et al., 2010).

The Importance of Communication

Ong et al. (1995) identify three main purposes of doctor-patient communication: 1. Building a relationship; 2. Exchanging information (information giving and seeking), and 3. Making decisions regarding treatment(s). The first, building a relationship, is an often neglected part of health consultations today, but it is a prerequisite for effective medical care (Ong et al.,
While researchers differ in terms of what makes a relationship “good,” most agree that trust is a particularly important component (Gordon & Gerber, 2010; Hingle & Robinson, 2009; Mueller et al., 2004), especially since healthcare interactions require significant personal disclosure and vulnerability on the part of the patient (Skirbekk, Middelthon, Hjortdahl & Finset, 2011; Gruber & Frugone, 2011).

Patients with chronic illnesses often require more open relationships with their physicians before they are willing to trust their doctor completely. They need to feel that the physician is interested in them as a person, and does not see them as merely a bundle of symptoms (Skirbekk et al., 2011; Gruber & Frugone, 2011). Good communication is key to building a relationship with these patients since more complicated diseases require more complicated consultations, and therefore more open trust between patient and doctor. Because chronic diseases impact lifestyle more significantly than acute, the patient must feel comfortable discussing these impacts with their physician in order to receive the best treatments possible. If the patient feels they have made a connection with the physician on a more personal level, the patient will be much more willing to put faith in their physician (Skirbekk et al., 2011).

By focusing on building a relationship with one’s patients, doctors can improve their ability to accurately diagnose and treat them. When a trusting relationship has been established through effective communication, patients become more likely to share symptoms and concerns, follow-through with physician recommendations, follow medication and/or treatment regimens, and self-manage their illnesses more effectively (Hingle & Robinson, 2009). Doctors also gain insight into patients’ cultural orientations, health belief systems, and psychological orientations towards their conditions, which allows them to create more individualized and informed treatment plans (Langer & Ribarich, 2009).
In terms of empirical evidence, research shows that specific benefits of good doctor-patient communication include: better treatment adherence (Fenton, Jerant, Bertakis. & Franks, 2012), better treatment outcomes, fewer malpractice lawsuits, and greater patient satisfaction (Ommen et al., 2008; Langer & Ribarich, 2009; Kurtz, 2002; Robinson, White, & Houchins, 2006). These results are likely achieved because effective communication can exert “a positive influence not only on the emotional health of the patient but also on symptom resolution, functional and physiologic status and pain control” (Shue & Arnold, 2009, p.146-147). When patients feel cared-for, they are more likely to believe they will get healthy again (Gruber & Frugone, 2011), thus they are more likely to follow-through with treatment plans that will help them attain good health.

Of course, there exists a wide variety of physicians and each has a different preferred style of communication (Street et al., 2007). This communication style may be the result of repeated experiences with certain types of patients, a physician’s philosophy and beliefs regarding health care, their gender socialization, and their medical training (Street et al., 2007). What is undeniable is that physician communication style influences patients (Stewart et al., 2000; Gordon & Gerber, 2010).

**Three Main Theories of Communication**

With the diversity of age-groups that are represented in our population today comes a diversity of preferences and views regarding medical authority and interaction style. To date, three main models of interaction have been articulated in the theory that discusses doctor-patient communication. These models include the Paternalistic model, the Consumer model, and the Mutual model.
**The Paternalistic Model of Doctor-Patient Interaction**

The paternalistic model is characterized by guidance-cooperation roles of the doctor and patient respectively; as such, an overwhelming power-differential exists between the doctor and the patient (Morgan, 2003; Potter & McKinlay, 2005). This power differential consists of high physician control and low patient control. Due to this power differential, the doctor retains authority over the patient as a parent figure does over a child. The patient is therefore required to cooperate and go along with whatever diagnosis and treatment strategies the doctor recommends (Morgan, 2003).

Trust within this model of doctor-patient relationship exists in two realms: The patient trusts that the doctor will diagnose and treat the illness properly, and the doctor trusts that the patient will cooperate and comply with treatment. Trust is also built around the patient’s respect for authority, the education of the doctor, the patient’s faith in the doctor’s skills, and the doctor’s desire to serve the best interests of the patient.

Communication under this model is characterized by the doctor dominating the conversation through closed-ended and specifically-directed questions, a focus on the physical aspects of the patient’s illness to the exclusion of psychological or other aspects, and a tightly controlled medical interview.

**The Consumer Model of Doctor-Patient Interaction**

Under the consumer model of doctor-patient interaction, the doctor is seen as the provider of services that are consumed by the client (the patient). The consumer model is the opposite of the paternalistic model and is characterized by high patient power and low physician power (Morgan, 2003). Instead of being seen as a relationship that is developed around mutuality, trust, and growth over time, the consumer relationship is seen as a contractual exchange whereby the
patient sets the agenda, directs the medical interview, and often comes to the doctor armed with greater scientific and medical knowledge than traditionally possible (Heritage & Maynard, 2006). As a result, the patient narrative is favoured; patient values are clear though not necessarily discussed (Heritage & Maynard, 2006); the patient makes most of the decisions regarding their treatment (Hellín, 2002; Heritage & Maynard, 2006); and the patient pursues a particular end such as a diagnosis or a prescription, directing the interaction in order to meet this end.

In turn, the doctor takes on a more passive role, acceding to the patient’s needs for information, referral, second opinion, and the provision of diagnosis and treatment. Overall, the doctor’s function is to help the patient appropriate his or her illness (Hellín, 2002) and is therefore seen as a technical consultant (Heritage & Maynard, 2006).

Trust within the consumer model seems largely absent; if it does exist, it is built around the doctor’s trust that the patient is providing accurate and specific illness and treatment-related information, and the patient’s willingness to trust the doctor’s diagnoses and treatment recommendations based on the doctor’s ability to consistently provide the desired health services and results.

**The Mutual Model of Doctor-Patient Interaction**

The mutual model is often referred to as the patient-centred model (see Heritage & Maynard, 2006), or the biopsychosocial model (Smith, Dwamena, Grover, Coffey, & Frankel, 2010). Within this model, both parties are expected to hold equal or almost equal power over diagnosis (through each party’s ability to contribute to accurate diagnosis by sharing knowledge and experience of the patient’s symptoms, illness triggers, etc.), and especially treatment; as such, interaction between doctors and patients who engage under this model is very cooperative,
with the agenda and goals of the meeting being set by both parties (Heritage & Maynard, 2006). The goal is to bring together two different knowledge perspectives to solve the mystery of the illness afflicting the patient, including the patient’s knowledge of his or her experiences of the illness, and the doctor’s skills, clinical knowledge, diagnostic techniques, treatment options, and preventative strategies (Morgan, 2003). Within this model, the doctor is seen less as a parental-figure and much more as an advisor (Heritage & Maynard, 2006).

Due to the mutual nature of the relationship, doctors generally spend more time actively listening to their patients. Communication becomes characterized by patient narratives and exploratory or open-ended questions asked by the doctor (Morgan, 2003). Patients also participate by asking questions, sharing their narratives, and by working toward an understanding of the diagnosis and treatment options.

Trust in this relationship is built on a “deep knowledge of the patient and their values, mutual confidence, and effective communication” (Hellín, 2002, p.452). The long-term relationship that is developed over time also contributes to the trust built between patient and physician (Potter & McKinlay, 2005).

**Review of Literature**

Recently, there has been a shift toward a focus on patient-centred communication as the main model of interaction taught to medical students (Sanders, 2009; Pilnick & Dingwall, 2011; Smith et al., 2010). While many researchers see this shift as a positive step toward improving accurate diagnosis and treatment for all patients (e.g. Bensing et al., 2011; Kurtz, 2002; Sanders, 2009), some authors argue that there is limited evidence to support the claim that patient-centred care is the solution to the need for better medical treatment (Pilnick & Dingwall, 2011; Smith et al., 2010; Fenton et al., 2012). Others argue that physicians must be flexible in their
communication abilities, adjusting their interaction styles depending on the patients’ preferred method of interaction (van den Brink-Muinen et al., 2006; Ommen et al., 2008; Street, Gordon, Ward, Krupat, & Kravitz, 2005); this is especially true when working with geriatric patients, who represent a very heterogeneous group of patients with unique medical needs (Belcher, Fried, Agostini, & Tinetti, 2006; Kruger, Prohaska, & Furner, 2007). These divergent opinions regarding patient-centred communication point to a need for further research into the communication needs and desires of patients, and the impact that meeting these needs can have on patient satisfaction, compliance, and wellbeing.

In addition to the diverse array of opinions regarding the benefits of patient-centred communication, many of the studies assessing the quality of doctor-patient communication are qualitative. As a result, they often fail to effectively influence policy. In the field of medicine, evidence-based studies are usually valued over qualitative insight when outlining and implementing policy. Defined as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients,” (Grypdonck, 2006, p.1373), evidence-based medicine derives its credibility from the integration of systematic clinical research trials and individual clinical expertise. Thus, any and all healthcare practices, from the questions used during the physician-patient interview, to administering certain drugs and treatments, must be supported by scientific research studies—more specifically, randomized control trials (Grypdonck, 2006). Due to qualitative researchers’ frequent use of subjective analysis and the difficulty associated with exactly replicating qualitative research studies, the evidence derived from qualitative research is relegated to the lowest rung on the “legitimate evidence” ladder (Grypdonck, 2006; Gewurtz, Stergiou-Kita, Shaw, Kirsh, & Rappolt, 2008).
Despite the lack of legitimacy attributed to qualitative research, healthcare providers, and nurses in particular, acknowledge the importance of qualitative research for understanding human interaction and for complimenting quantitative research findings (Zimmer, 2006). As a result, there has been a greater push for a qualitative methodology that can amalgamate the findings of qualitative studies and make them more accessible for evidence-based practice, namely, qualitative meta-synthesis (Finfgeld, 2003).

My research seeks to fulfill three main purposes: (a) to continue the discussion regarding geriatric patient needs and desires during the medical encounter (b) to contribute to the growth of geriatric content within medical school curricula and (c) to inform the creation of a communication skills training tool, a VP, in order to amalgamate VP use with geriatric content. By bringing together multiple socio-medical qualitative studies that look at geriatric patients’ perspectives, my research also seeks to create an evidence base that is valued by both medical practitioners and policy-makers.
CHAPTER 3 - META-SYNTHESIS

Research Questions

According to Junius-Walker et al. (2011), despite the emphasis on communication skills training in medical education programs, general practitioners and geriatric patients continue to prioritize treatment and health concerns differently. Many researchers agree that the most effective means of ascertaining the needs and priorities of patients is by asking patients directly (Kurtz, 2002; Sanders, 2009; Bensing et al., 2011). As such, this study seeks to answer the following questions:

1. What common communication barriers and/or facilitators do geriatric patients identify when reflecting on their interactions with doctors?
2. What suggestions, tips, or pointers are offered by geriatric patients and the literature regarding ways doctors can improve the physician-geriatric patient interaction?
3. What socio-cultural factors exist within physician-patient communication that could present further barriers to communication between physicians and geriatric patients?

Delimitations

This study is limited to 16 carefully selected peer-reviewed socio-medical journal articles written using qualitative methods including case studies, ethnographies, phenomenologies (i.e. studies that focus on the lived experiences of individuals in order to understand a specific event (Jackson, Gillis, & Verberg, 2007)), mixed methods studies, and grounded theory studies. The articles are all written in English and all focus on geriatric patient perspectives. To keep the study relevant, only articles that have been published between 2000 and 2012 are included.
CHAPTER 4 – METHOD

Research Design

This study is a meta-synthesis, which, according to Finfgeld is “the synthesis of findings across multiple qualitative reports to create a new interpretation” (2003, p.895). The meta-synthesis involves “rigorously examining and interpreting the findings (versus the raw data) of a number of qualitative research studies using qualitative methods” (2003, p.894) with the goal of producing a new interpretation of the findings.

The findings of this meta-synthesis will inform the creation of a VP that will serve as an interactive training module designed to facilitate student insight into the perspectives of geriatric patients, as well as to provide an opportunity for students to apply the knowledge they gain regarding improved communication practices. The first part of the training module will require students to watch three separate doctor-patient interactions, each of which will be followed by a quiz that tests the student’s ability to identify common communication barriers and facilitators. This section will be followed by an information sheet that will provide students with strategies on how best to communicate with geriatric patients. The data for this document will be derived from this meta-synthesis. Once students have had the opportunity to review this document, they will be directed to the second part of the module. This section will be an interactive “choose-your-own-adventure” game that will allow the student to implement the new knowledge they have gained. The video will be filmed from the physician’s perspective, allowing the student to direct the consultation with the proper communication practices in mind.
Data Collection

Due to the interdisciplinary nature of the topic, extensive searching through multiple databases was required. Research was conducted in 2012, between June 26 and July 15 inclusively. Appendix 1 outlines each database searched, with corresponding keywords and the number of articles per database extracted for further review. Appendix 2 includes the saved search histories for some of the searched databases.

The following keywords were the most commonly used keywords to obtain the articles for this study: communication* OR interaction AND senior* OR elder* OR geriatric OR old* AND doctor OR physician OR practitioner AND qualitative OR focus group OR phenomenology OR interview* OR grounded theory OR ethnography OR case study.

Limitations included: peer-reviewed, publication dates between 2000-2012, use of a qualitative research method (this includes ethnography, case study, phenomenology, mixed method, and grounded theory), articles written in the English language, and articles that provide the geriatric patient perspective.

After several searches in multiple databases, 185 articles pertaining to physician-patient communication were selected based on article title. Initially, articles were only included if they focused on North American, community-dwelling, naturally-aging geriatric patients (i.e. patients that were only diagnosed with common chronic conditions such as heart disease, diabetes, or limited sensory impairment and excluding diseases that impair communication abilities such as dementia, aphasia, etc.); however, not enough studies included subjects that met this criteria as most medical research focuses on patients suffering from specific diseases and very few medical studies feature geriatric patients as subjects. Instead, the inclusion criteria was expanded to include studies conducted with community-dwelling geriatric patients, mostly experiencing
natural aging processes [this could include disease-specific articles as long as the disease was part of common illness/diseases experienced by geriatric patients (see: A Portrait of the Geriatric Patient on page 10 of this report)], and living in Western countries where culture and population demographics are similar to those in North America (i.e. European and Scandinavian countries).

Upon review of the remaining abstracts, the list of 185 articles was culled to 30 options meriting further investigation. After reading each article, 16 were selected for final inclusion in this study.

**Inclusion criteria**

- Only peer-reviewed articles
- Only articles published between 2000-2012
- Only articles following a qualitative method
- Only articles relevant to the topic
- Only articles written in the English language
- Only articles focused on the views of geriatric patients

**Exclusion criteria**

- Articles that were not peer-reviewed
- Articles published before the year 2000
- Articles that did not follow a qualitative method
- Articles not relevant to the topic
- Articles not written in the English language
- Articles focused on the views of doctors
- Articles that looked at communication between geriatric patients and pharmacists
Exclusion criteria continued

- Articles that assessed hospitalized geriatric patients
- Articles that dealt with end-of-life issues

Data Analysis

Data found in the remaining selected articles was coded according to theme, as is common in many qualitative studies. In accordance with a process described by Finfgeld, the data analysis of the selected articles included beginning with “a list of codes and examin[ing] each study in isolation before synthesizing the coded data” (2003, p.900).

A basic coding legend was created, detailing various categories (with some examples) of communication barriers and facilitators (see Appendix 3). This legend was used to assess and colour-code the 16 selected articles. As the articles were reviewed, subcategories and related subthemes were extracted and added to the coding legend. Once the first analysis was complete, the articles were assessed again. This time, information from the articles was categorized within the various identified subthemes and subcategories. The information was listed in the chart found in Appendix 4. Once this step was complete, the articles were assessed one final time to ensure coding consistency. Any new/missed data was inputted into the chart (Appendix 4) in the colour red in order to provide transparency of the coding process.

Considerations of Trustworthiness

To enhance the trustworthiness of this study, only peer-reviewed articles were included. Also, only articles that made multiple references to raw data in their findings sections were included. Finally, the detailed data-collection section and accompanying appendices creates an audit trail that can be followed and verified, enhancing the credibility of this study.
CHAPTER 5 – FINDINGS

The articles in this study afforded rich insight into the needs and wants of geriatric patients. Though each study assessed the opinions of a unique set of participants, combined, these studies bring together the findings and discussions of 16 qualitative articles representing the views of 1,199 patients, 434 of which were male and 765 of which were female. The majority of these studies were conducted in the United States (56%) and the rest were conducted in Western Europe and Canada. While a few of the studies included participants from lower socio-economic backgrounds, most assessed the views of elderly patients with middle to high economic backgrounds who had an average of high school to some college or university education. Some cultural and ethnic diversity was represented in a few of the studies, but the majority identified participants as Caucasian and/or white/non-Hispanic white.

Many themes became apparent during the analysis of the 16 articles. Though these themes are clearly interlaced when painting the bigger picture of doctor-geriatric patient communication, the themes have been represented in the findings according to the type of communication barrier or facilitator under which they fell. While the list of themes was extensive, only themes that were mentioned in 50% or more of the articles are highlighted in the findings section. The discussion section of this paper will provide greater insight into the connections between the findings, as well as the connections these major themes had with some of the less frequently cited themes.

Structural and Contextual Barriers and Facilitators

For the purposes of this study, structural or systemic barriers were defined as barriers to communication that are due to issues inherent in the overall medical and/or greater socio-cultural system (Western-world). These barriers are not the result of specific, individual, or isolated
factors. If the structure, organization, or policies of a system were to change, they could alleviate the systemic problem. Contextual facilitators were identified as specific situational circumstances that enhance physician-patient communication. These situational circumstances were seen as specific to the relationship held between a particular patient and his or her physician as it was not productive to assume that the facilitator was the result of a systemic or structural situation.

**Time (Barrier and Facilitator)**

Time was a major theme throughout the majority of the articles. Where short consultation times were seen as a barrier to active patient participation, longer consultation times were considered desirable for facilitating patient participation and building the patient-physician relationship. Many participants across studies noted that short consultation times prevented them from grasping information provided by the physician (Bastiaens, Royen, Pavlic, Raposo & Baker, 2007) and developing mutual respect with physicians (Belcher et al., 2006). Time played a fundamental role in determining patients’ experiences with their physicians as positive or negative, with patients indicating that a perceived or actual lack of consultation time prevented patients from being able to build relationships with their providers, and also prevented them from discussing sensitive matters with their physicians (Evans & Robertson, 2009; Tannenbaum, Nasmith & Mayo, 2003; Gantert, McWilliam, Ward-Griffin & Allen, 2008; Schulman-Green, Naik, Bradley, McCorkle & Bogardus, 2006). Only one patient mentioned seeing short consultation times as positive, indicating that he took comfort from the fact that a short consultation meant he was doing okay (Bungay & Cappello, 2009).

Longer consultations, on the other hand, were viewed positively by the majority of patients. In order to have more time with physicians, some patients requested double
consultations (Berkelmans, Berendsen, Verhaak, & van der Meer, 2010); as Evans and Robertson iterated in their study, “one visit may be more lengthy and participatory, but it reduces the need to make multiple office visits and associated charges” (2009, p.428). Patients cited feeling happier and more confident with their treatment plans when they felt that their physician had taken time to adequately address their concerns. Longer consultation times facilitated this process, preventing both the physician and patient from feeling rushed. For some patients, taking time was associated with the physician taking an interest in (Bastiaens et al., 2007) and caring about the patient (Tannenbaum et al., 2003). Patients also appreciated when caregivers allowed time for simple conversation to occur as patients felt that mutual knowing was an important aspect of their relationship with their providers (Gantert et al., 2008; Woolhead et al., 2006).

**Continuity VS Lack of Continuity and the Doctor-Patient Relationship**

Almost all the articles mentioned the importance of continuity of care as a facilitator of communication. According to Bayliss, Edwards, Steiner & Main, continuity consisted of “knowing (and being known by) their providers for a period of time” (2008, p.290). Continuity was seen as more important to patients than convenience, with many participants indicating that they had chosen to follow their providers to new cities rather than find a new local provider (Bayliss et al., 2008; Tannenbaum et al., 2003). Continuity was said by patients to save time by preventing patients from having to repeatedly re-educate providers on their complex healthcare needs and medical history (Gantert et al., 2008). Patients also mentioned the importance of continuity of other healthcare providers at the physician’s office, including nurses and receptionists (Bayliss et al., 2008). This continuity provided patients with a sense of safety and trust in both the physician and the physician’s healthcare team, as illustrated by Berkelmans et al.: “A familiar voice, face or name when [patients] contact the practice appears to be very
important…and is used in combination with terms like ‘trust’, ‘safe’, ‘personal’, and ‘nice’” (2010, p.6). Several patients mentioned wishing that their general practitioner could still attend to all their needs instead of sending them to specialists, valuing the safety and trust they felt due to their ongoing relationship with their general practitioner. Patients who reported longer continuity relationships with their providers appeared more satisfied with their doctor-patient interactions than those who did not have continuity (Shapiro, Mosqueda & Botros, 2003); this was partly attributed to patients’ opportunity to build trusting relationships with their physicians, allowing them to feel more comfortable interacting with their care providers (Gantert et al., 2008).

As an extension of continuity of care, long-term and personal relationships in which the physician knew the patient well, was considered a facilitator to communication. For the elderly, the personal relationship to their doctor was seen as extremely important (Bastiaens et al., 2007), particularly for the development of trust (Bungay & Cappello, 2009; Tannenbaum et al., 2003). A few patients indicated that, while some patients may feel a connection with their physician right away, most times a good rapport, and even friendship, is built over time (Evans & Robertson, 2009; Gantert et al., 2008). Patients also indicated that they were not able to talk to their physician about more sensitive topics such as personal goals, until rapport had been developed (Schulman-Green et al., 2006). One patient in particular illustrated the importance of a long-term relationship with providers through his experience working with an African American caregiver. Initially, the patient was unwilling to cooperate with the provider due to his prejudice, but over time, he grew to know her as a person and became much more comfortable with her as his provider (Gantert et al., 2008).

Frequently, patients mentioned wanting to be known by their providers (Gantert et al., 2008; Schulman-Green et al., 2006). Patients expressed wanting their physician to know what
made them “tick”, so they would recognize when a patient was feeling “off” (Shapiro et al., 2003). Being remembered by physicians was an important aspect of being known; when physicians remembered a patient’s name, even if the patient had not seen the provider in a few years, patients felt valued (Teh et al., 2009). Patients placed a high priority on having a meaningful relationship with providers and particularly wanted to feel as if the physician understood them as a person (Teh et al., 2009). Patients also mentioned that the best interactions between themselves and their physicians occurred when both parties knew each other well (Tannenbaum et al., 2003).

Alternatively, lack of continuity, found in places like group practices (Bastiaens et al., 2007; Berkelmans et al., 2010), or in situations when patients had multiple specialists, was seen as a communication inhibitor. Not only did lack of continuity cause difficulty for patients in terms of their participation (Belcher et al., 2006), leaving them to feel uncomfortable having intimate discussions (Schulman-Green et al., 2006) but it also made dealing with worrisome or scary health situations more stressful and confusing (Berkelmans et al., 2010). In one study, patients even indicated that they preferred to have no contact with providers they did not know (Berkelmans et al., 2010). Lack of continuity was also said to hinder the relationship development and trust between patients and physicians (Bungay & Cappello, 2009; Gantert et al., 2008).

**Attitudinal Barriers and Facilitators**

Attitudinal barriers and facilitators were defined as perceptions, prejudices, beliefs or desires held by the patient or physician that either hinder or facilitate communication. The most commonly cited attitudinal barriers surrounded patients’ belief or perception that doctors held
superior, authoritarian attitudes and were not interested in patient care. These perceptions were further compounded by some patients’ views of the doctor as God.

Authoritarian Physicians and Patient Attitudes toward Authority

Many patients indicated that they did not like it when physicians attempted to take the lead during consultations (Price, Bereknyei, Kuby, Levinson, & Braddock, 2012). Patients who encountered physicians with rude, abrupt, and unfriendly attitudes felt ill-treated, describing their treatment as akin to being a piece of meat, or an object, that physicians simply wanted to be rid of as soon as possible. As a result, patients often felt unwilling or very unhappy about visiting these physicians (Bungay & Cappello, 2009). When physicians acted in an authoritarian manner, patients often resisted by either refusing treatment outright (Gantert et al., 2008) or subverting treatments by failing to adhere to treatment plans. Some patients complained about having doctors who were unwilling to work with them to achieve an agreeable treatment outcome (Teh et al., 2009) while others complained about frustrating interactions with physicians who were dismissive or patronizing (Shapiro et al., 2003). Authoritarian attitudes held by physicians that emphasized the exclusion of patient participation also “affected the older persons’ experience of dignity, especially if they were scolded” (Woolhead et al., 2006, p.369).

A perceived lack of interest on behalf of a physician was also seen as a deterrent to patient participation. Lack of interest in the patient was acutely perceived and often led to patients withholding information (Gantert et al., 2008; Bastiaens et al., 2007; Belcher et al., 2006). One patient felt that an ageist attitude was a particularly bad attitude for physicians to project because it made the patients feel uncared for (Bungay & Cappello, 2009); such attitudes also caused patients to lose trust in their physicians (Shapiro et al., 2003). Another patient discussed feeling as if her physician lacked concern for her need of a knee replacement, which
was especially evident through his reluctance to refer the patient to a surgeon (Evans & Robertson, 2009). When patients felt that their caregivers did not appreciate the struggles they were enduring, they became frustrated with themselves and with their providers (Gantert et al., 2008). Patients also complained of feeling as if they meant nothing to their doctors: “…many of the older participants had the impression that they were not considered as persons nor were they respected for their opinions or views” (Woolhead et al., 2006, p.370).

Further compounding the issue of authoritarian physicians were patients who saw their physician as an authority figure not to be questioned. Many patients believed that the doctor knew best and that the patient should simply adhere to whatever decision the doctor made (Belcher et al., 2006). In one study, patients saw doctors as experts and professionals and as such, they were unwilling to question their physicians (Bungay & Cappello, 2009). A positive side to this view of authority was that some patients saw physicians as authority figures that could provide adequate information for patients to make health and treatment decisions (Bungay & Cappello, 2009); however, most patients saw physician authority as unquestionable, even seeing themselves as passive objects to be cared for by their providers whose status and expertise gave them greater authority over medical decision-making (Gantert et al., 2008).

Seniors cited being “…occasionally intimidated by providers’ status and [were] therefore not always forthcoming about their own needs, motives, expectations, and contributions” (Gantert et al., 2008, p.30). Others “expected the clinician to be a technical expert and authority in the relationship, so patients’ goals were not significant [topics of discussion]” (Schulman-Green et al., 2006, p.147). Some patients indicated that they would never disagree or question their doctor’s authority (Teh et al., 2009), which was an attitude that caused one patient to almost
lose her life (Evans & Robertson, 2009). As a result of this situation, the patient was unable to develop a trusting relationship with any other healthcare providers.

**Caring Doctors seeing Patients as Individuals**

Patients valued physicians they perceived to genuinely care for them. This genuine care was demonstrated through such behaviours as knowing the patient, asking for the patient’s perspective or opinion, and “taking time” during medical consultations (Bungay & Cappello, 2009). A particular aspect of caring for some patients was a physician who took an interest in geriatric care; this was demonstrated through physician patience, enjoyment of their work, and a determination to learn about geriatric issues and find the correct diagnosis and treatment to help their patient (Bungay & Cappello, 2009). Patients also valued physicians who were interested in learning about patients’ various diseases and disabilities (Shapiro et al., 2003) and any kindness displayed by physicians was said to always be cherished (Woolhead et al., 2006). Overall, older patients valued “a caring relationship that is characterised by trust, support, communication, taking an interest and a person-centred attitude” (Bastiaens et al., 2007, p.40).

This caring attitude on the part of physicians also shone through when patients perceived that physicians saw them as individuals with unique illness needs. Many patients indicated an interest in physicians that provided individual attention and care (Evans & Robertson, 2009). They valued physicians who went beyond the signs and symptoms and took into consideration the patients’ life context and personal values (Price et al., 2012; Berkelmans et al., 2010; Gantert et al., 2008; Teh et al., 2009). Patients also valued patient-centred communication (Bayliss et al., 2008; Tannenbaum et al., 2003).
Mutual Trust and Respect

Trust was seen by patients as both a facilitator of communication as well as a barrier. Too much trust in the doctor was seen to hinder communication as patients would not ask questions or discuss treatment, instead relying solely on the doctor’s decision. Others saw trust as a facilitator, and even a prerequisite, to communication, stating that trust allowed patients to learn better from their physicians, especially if they perceived their physician to be caring (Bungay & Cappello, 2009). Patients often felt that adequate time and respect were necessary for them to feel comfortable with speaking freely with their general practitioners (Berkelmans et al., 2010). Others indicated that trust could not be built unless there was “longitudinal follow-up over the course of many months or years” (Tannenbaum et al., 2003, p.9); when trust was achieved, however, patients felt that it allowed them to more comfortably discuss intimate matters with their physicians (Schulman-Green et al., 2006).

Actions on the part of the physician that helped to increase patients’ trust and comfort within the relationship included seeing things that patients could not see themselves, taking illness seriously, and providing quick referrals when necessary (Berkelmans et al., 2010). Patients also saw forms of address as indicators of respect and did not respond well when physicians addressed them with cute names, or on a first name basis, unless the patient had specifically introduced themselves by first name (Woolhead et al., 2006).

Often trust meant trusting the physician’s opinion. Patients indicated that they felt comfortable asking for, and following their physician’s recommendations because they trusted that their physician would never steer them wrong. (Bungay & Cappello, 2009; Price et al., 2012). While an over-abundance of faith in the doctor as God, as seen previously, was a potential hindrance to doctor-patient communication, patients indicated that reasonable trust was
necessary to have a good, productive relationship with a physician (Evans & Robertson, 2009). Mutual respect was seen as important for facilitating a good relationship as well, with patients indicating that they needed to respect providers’ ways of doing things, but that providers also needed to respect the views and opinions of patients (Gantert et al., 2008). A trusting and mutually respectful relationship was determined to be very important to patients’ satisfaction with their care (Teh et al., 2009). Lack of a trusting relationship was perceived to sometimes be the cause of physicians and patients not providing enough information during consultation (Price et al., 2012).

**Desire for Health Information and Desire to Participate**

Patients differed in their preferences for involvement within the doctor-patient relationship. One form of involvement the majority seemed to prefer was receiving health information regarding their conditions so they were either better able to follow their physician’s treatment recommendations, or better able to participate within the medical encounter. Many patients wanted information regarding their illness and treatment, particularly with regard to diet, exercise, and other lifestyle practices that could improve life with their conditions (Xie, 2009; Tannenbaum et al., 2003; Evans & Robertson, 2009; Bungay & Cappello, 2009). Information was said to help patients cope with the stressful situation of being sick (Xie, 2009). Patients valued physicians who explained what was wrong with them and who answered their questions (Bungay & Cappello, 2009).

Some patients described searching for their own health information on the Internet, or asking friends who had experienced similar conditions (Evans & Robertson, 2009; Teh et al., 2009). Other patients suggested that physicians or healthcare facilities set up support groups within the community to help educate patients on the natural aging process, lifestyle aids and
hindrances to maintaining good health, and information regarding certain specific diseases and conditions. In one study, some of the participants had already set up a health group where they could discuss the health issues they were all experiencing as they aged. This group offered patients a way to share health information and experiences to make the process of aging less difficult and scary (Evans & Robertson, 2009).

As an extension of desiring health information, many participants felt that the patient could, and should, participate in the doctor-patient interaction (Belcher et al., 2006). Patients saw such behaviours as gathering information so they could help participate in decision-making (Bastiaens et al., 2007; Xie, 2009), asking questions regarding diagnosis and treatment, and providing information to the doctor regarding signs and symptoms, as behaviours that assisted with accurate diagnosis (Belcher et al., 2006).

Many patients indicated wanting to participate in their healthcare. For example, the women interviewed by Evans and Robertson wanted their needs and desires discussed, and they wanted to help make decisions regarding their treatment plans (Evans & Robertson, 2009); they were “seeking participatory spaces in which to plan their health care” (Evans & Robertson, 2009, p.423). They saw these spaces being created when the physician participated in a dialogue, offering choices to the patient and allowing the patient to participate in the discussion (Evans & Robertson, 2009).

Patients most often indicated that they wanted their preferences heard and acknowledged by the physician as the extent of their participation in decision-making (Price et al., 2012; Evans & Robertson, 2009). One patient indicated that, even when the physician knew the answer, it was appreciated when the physician would ask the patient (Gantert et al., 2008). Doing so made the patient feel that their ideas were important and that they were still valuable (Gantert et al., 2008).
**Behavioural Barriers and Facilitators**

Behavioural or specific communication-related facilitators and barriers were defined as actions that enhanced or hindered the transmission, translation, and/or comprehension of a message communicated either non-verbally or verbally, by the physician or the patient.

**Appearing Rushed**

When participants felt the doctor was too busy, they became frustrated (Evans & Robertson, 2009) and were reluctant to participate in the interaction (Bastiaens et al., 2007). This theme was mentioned in several of the articles, with patients often complaining that their physician was always in a hurry to get through appointments (Shapiro et al., 2003; Bayliss et al., 2008). Actions that portrayed a sense of hurry included close-ended questioning, inching for the door upon entering the consultation room (Bungay & Cappello, 2009), and failing to address patient questions and concerns. When the doctor looked as if s/he was in a hurry, patients mentioned feeling intimidated and unwilling to bring up information (Tannenbaum et al., 2003). One patient even emphasized how detrimental to the interaction that physicians’ looking at their watches could be. To patients, glancing at one’s watch indicated that the physician was not interested in them, was not listening, and overall, did not believe the patient was important (Bungay & Cappello, 2009).

**Patient Participation**

Some patients believed themselves to be primarily responsible for their own health. They saw it as their responsibility to contribute to their care by becoming informed, and asking their physician questions (Gantert et al., 2008; Shapiro et al., 2003). This sense of responsibility did not emerge out of spite for physicians, but out of a recognition that doctors were only human and
were capable of making mistakes; patients therefore saw a need to avoid simply relying on physicians for all their health information and needs (Shapiro et al., 2003).

Many patients indicated that they asked questions regarding treatment, sometimes challenging their physician’s treatment plans. Patients also told their physicians how they wanted to be involved, with one patient indicating that she would be the one to tell the doctor if she needed a hip replacement (Price et al., 2012). Many older adults with chronic pain actively participated in treatment decisions. They frequently asked for, or refused certain treatments, and spoke up for themselves when they felt they were not being treated properly (Teh et al., 2009).

Patients also sought their own health information, which allowed them to feel more confident when speaking with their physicians. One patient talked about gathering the names of knee replacement surgeons from her friends at church so that she could get her doctor to finally provide her with a referral (Evans & Robertson, 2009). Overall, being involved and assertive during their healthcare interactions was seen as a positive behaviour for patients in a large number of articles assessed.

A Doctor Who Listens

Many patients said they valued a physician who listened (Berkelmans et al., 2010; Bastiaens et al., 2007) and that listening was an important aspect of interactions with their physicians (Price et al., 2012; Shapiro et al., 2003). Listening was equated with caring and taking an interest in the patient (Bungay & Cappello, 2009). Listening helped patients feel valued (Woolhead et al., 2006) and also helped patients feel that they were participating in their healthcare.

Patients wanted physicians who listened to their needs and concerns (Teh et al., 2009) and they mentioned that physician listening was confirmed when physicians accurately
addressed these concerns (Tannenbaum et al., 2003). Listening was also said to preclude trust (Teh et al., 2009) and allowed patients to value the treatment recommendations of their physicians. When patients perceived that their physician was not listening, patients were apt to believe that their doctor did not understand the patient's complication; this lead to patients failing to adhere to physicians’ treatment recommendations due to their belief that their physician misdiagnosed or mistreated their condition.

**Providing Adequate and Clear Information**

Patients wanted physicians to answer all their questions and provide detailed and comprehensible explanations (Shapiro et al., 2003). Patients indicated that, in order for patients to be involved in their care, they needed clear information and treatment choices that were explained using layman’s language (Belcher et al., 2006; Barnes et al., 2006; Bungay & Cappello, 2009). Patients recommended the use of tools to assist in explaining complicated conditions and/or treatments (Bastiaensen et al., 2007). Trust was also equated with receiving adequate and clear information (Price et al., 2012).

**Physical Barriers**

Only one physical barrier was mentioned enough to merit inclusion in the findings section of this paper. Physical barriers were defined as barriers to communication that were due to bodily or space-related complications on the part of the physician or the patient. Physical barriers included such things as hearing loss, vision loss, and mobility difficulties as well as access issues such as lack of handicap parking or accessible entrances to physician offices. The physical barrier that was mentioned in 50% of the articles was that of memory loss.

Forgetfulness was frequently mentioned as a hindrance to doctor-patient communication (Woolhead et al., 2006; Barnes et al., 2006; Bayliss et al., 2008; Bastiaens et al., 2007). Many
patients indicated a need to receive information in writing to help counter this difficulty with their memory (Bayliss et al., 2008). For heart failure patients, confusion and short term memory loss made communicating with providers extra difficult (Barnes et al., 2006). In many of the studies, patients either indicated the need to take companions with them, or recommended for others to take companions to their doctor visits in order to help remember important health information (Price et al., 2012; Bungay & Cappello, 2009). Common problems that also influenced patient involvement within the medical encounter included poor hearing or vision, and being less mobile (Bastiaens et al., 2007).

**Tips and Pointers**

Many of the articles offered tips and pointers either from the mouths of the participants, or through the authors’ analyses of the information offered by participants. The tips most frequently cited in the studies included the recommendation that:

- Physicians should recognize patients’ knowledge of their bodies, and the uniqueness of each patient’s experience with illness. With this recognition, physicians should base their method of communication on common expectations and boundaries, which can only be gained by *asking the patient directly* what type of information they want, how much information they want, and how they want to participate in the doctor-patient interaction. An individual and flexible approach is therefore needed with each and every patient.

- Physicians should use tools and diagrams to help patients remember information. Physicians also need to remember to provide patients with clear written directives using laymen's terminology.

- Patients often wanted information on how to manage their chronic illnesses, how to identify the difference between natural aging and potential illness, and how to maintain a
healthy lifestyle. Many recommended offering wellness seminars or courses within the community to help patients learn about the natural aging process. Others thought that support groups would be useful. Patients felt that doctors should know about similar services offered by community centres so they could direct patients to them.

Further tips and pointers derived from this study, as well as the greater body of literature, can be found in Appendix 5.
CHAPTER 6 – DISCUSSION

Interpretation of Findings

One of the most significant findings of this study is the fact that many of the patients interviewed indicated that they wanted to participate in their healthcare encounters. This finding directly contradicts the notion of the passive patient discussed in a previous section of this paper titled A Portrait of the Geriatric Patient. While this sense of participation differed depending on the patient, sometimes being partially developed though the act of simply seeking health information, and at other times through active decision-making, most patients felt that participating in some form was important for good communication with their physicians. Participation took the form of asking questions, seeking health information both within the clinical encounter as well as through various alternative resources, and being assertive regarding expression of opinions. This finding is interesting considering the fact that many studies found that older patients ask fewer questions, interrupt less often, give more socially desirable responses, show more gratitude, and are less likely to express complaints (Stewart et al., 2000; Hildebrand, 2007; Strauss & Tinetti, 2009; Gordon & Gerber, 2010; Vandenberg, 2001).

The major exception to this desire for participation rested with male prostate cancer patients, who felt that the physician was an expert and authority figure not to be questioned. A few patients also indicated an unwillingness to participate, either out of fear of being provided with information that would scare or upset them, or due to the perception that the doctor held godlike authority, and therefore one must simply obey.

Regarding patient participation, many patients agreed that the desire to participate precluded participation. However, they also conceded that patient participation did not solely rest on a desire to participate, but also depended on both a supportive context and a supportive
physician. This notion is supported by the literature, which indicates that the attitude of the physician and the patient can impact the patient’s willingness to participate (Gordon & Gerber, 2010).

Many of the patients suggested that trust was a necessary component of the doctor-patient relationship that allowed patient participation to occur. When patients trusted their physicians and felt that their physicians cared about them, they were more willing to ask questions and to discuss sensitive matters. However, trust relied on several other components in order to develop, including continuity of a care provider over a longer period of time, the perception that one’s physician cared about and was invested in improving the patient’s quality of life, the time available for each consultation, and the physician’s ability to look past the disease to see the individual that existed within a particular context and carrying a unique history of experiences. These findings are echoed in the literature on trust between patients and physicians; Skirbekk et al. outline five elements that have been associated with open trust, including:

(a) the physician showing an early interest in the patient (e.g. demonstrating knowledge of patient’s history), (b) the physician showing sensitivity to patient emotion, (c) the physician giving the patient and the relationship time (both in each consultation, and over history of relationship/continuity), (d) establishing alliances against a common adversary (e.g. against illness), and (e) instances of bracketing normal role behavior, e.g., through a shared sense of humor (2011, p.1186).

In addition to having a trusting relationship with their physicians, patients needed to know that their physicians were supportive of patient involvement. This support was said to be demonstrated in many ways. The most frequently cited means of supporting patient involvement was listening. Physicians who listened attentively to patient concerns helped patients to feel valued and validated. When patients felt heard and understood they were more likely to trust their physician’s diagnosis and treatment suggestions. They were also more likely to adhere to
Patients felt that physicians supported patient involvement when physicians provided detailed health information in clear and understandable terms. Many patients alluded to the helpfulness of physicians who explained diseases and treatment plans using clear and comprehensible diagrams, written information, and other tools. These findings are consistent with the literature, demonstrating that active listening, information-giving and offering emotional support are trust-building behaviours for physicians that can serve to reduce anxiety experienced by patients (Ommen et al., 2008; Hildebrand, 2007). Finally, patients felt more apt to be involved when physicians provided them with choices. By providing patients with choices, physicians were actively seeking the patient’s opinion and input regarding treatment. This action helped patients feel involved in the clinical encounter, providing them with greater confidence in the treatment decisions made.

Interestingly, patients indicated that they did not always want to make final treatment decisions. While they wanted physicians to offer choices so they could provide their input on how they felt about each choice, they often wanted the physician to make the final decision; this could be due to the positive trust patients may have built with their physicians, allowing them to feel comfortable relying on their physician’s good judgement with the belief that their physician would take their individual needs and interests into account.

Patients also identified a number of communication barriers, including those related to authoritarian physician attitudes, patients withholding information, physicians appearing rushed during the clinical encounter, not having enough time during consultation, lack of physician continuity, and patients forgetting important health information due to cognitive decline. All these factors serve to hinder the communication between geriatric patients and physicians, and should therefore be avoided if possible. Obviously some of these barriers need structural changes.
to occur before they can be altered, such as the problem with short consultation times, but physicians can strive to achieve behavioural and attitudinal change in the meantime.

Surprisingly, a communication barrier that seems to be discussed often within the literature—ageism—was only mentioned in four of the 16 studies assessed. Ageism is defined as “negative perceptions of and prejudice against older people, which can significantly influence the care and treatment of older patients” (Adelman et al., 2007, p.1446). Within the literature, ageism is said to crop up frequently in the attitudes of physicians and medical students as a direct result of the ageist ideology that is rampant throughout our society. As Hammerschlag iterates, “…the idea of the aged or aging is anathema…Youth is the ideal in this society, and we relegate older people to…“grey leper” status” (Hammerschlag, 2008; p.61).

Negative stereotyping and the cultural influence on perceptions of aging and the elderly is said to pervade doctors’ interactions with their elderly patients (Vandenberg, 2001). Research demonstrates that older patients frequently receive less health education, information, and health counselling than younger patients (Hingle & Robinson, 2009) and studies show that many doctors perceive older adults as weak, poor, incompetent, and in need of help (Nussbaum & Fisher, 2009). Ageism is reflected in behaviours and actions such as: trivializing medical problems, using condescending language, providing less education and preventative regimens, offering little treatment for mental health issues, using derogatory names, spending less time on psychosocial issues, and stereotyping elders (Hingle & Robinson, 2009) as well as through physicians’ reluctance to work with older adults and their propensity to recommend fewer aggressive treatments or therapies (Roter, 2000).

Despite the prevalence of research demonstrating the continuing existence of ageism within medical encounters, there are many potential reasons as to why ageism was not mentioned
in the majority of the studies assessed. Perhaps patients were not aware or were unable to identify ageism as such; or perhaps, as Roter (2000) has shown, ageism does not appear to be a systemic issue in the routine communication that occurs between physicians and their elderly patients. Regardless, the lack of commentary on ageism within the assessed studies is interesting considering the prevalence of research on ageism that continues to demonstrate its persistent existence.

Another interesting finding was that only one study mentioned low-literacy as a barrier to patient communication. As mentioned earlier, low-literacy can reduce a patient’s ability to convey health-related descriptions and is also related to a person’s ability (or lack thereof) to understand verbal communication (Roter, 2000). Literacy is therefore a key component of an individual’s sociolinguistic capabilities and can play a major role in patient communication and understanding during the doctor-patient interaction. Perhaps low literacy was mentioned in only one of the articles due to the educational make-up of most of the patients interviewed: The majority reported having achieved education at a high-school level or higher. Further research into the opinions and views of elderly patients with low literacy levels might therefore provide more insight into the ways in which this barrier can impact their communication with physicians.

Finally, a few of the studies cited physicians’ lack of knowledge of specific illnesses and treatments, particularly with regard to geriatric illnesses, as a barrier to communication; these findings point to a need for the incorporation of geriatric content in medical school curricula.

Ultimately, what can be gleaned from this study is that geriatric patients differ vastly in their desire for and ability to participate in the clinical encounter. This difference is supported by the literature available regarding geriatric patient preferences for decision-making (Lally & Tullo, 2012; Robinson et al., 2006; Adelman et al., 2000; Guralnik & Ferrucci, 2009; Belcher et
al., 2006; Barnes et al., 2006; van den Brink-Muinen et al., 2006; Ommen et al., 2008; Street et al., 2005; etc.). Due to these differences, many of the authors of the articles assessed for this meta-synthesis recommended that physicians ascertain patient preferences by directly asking patients how they want to be involved in their care. Authors also advocated for shared decision-making, which is defined as “the involvement of both patient and doctor, a sharing of information by both parties taking steps to build a consensus about preferred treatment and reaching an agreement about which treatment to implement” (Lally & Tullo, 2012, p.99).

With regard to the ongoing debate concerning patient-centred care, the findings of this research support a need for diverse methods and means for interacting with geriatric patients. Some patients clearly demonstrate a preference for a paternalist type of interaction with physicians though most in this study indicated a preference for a mutual interaction. In light of the indication that patients prefer or want to participate in interactions with their doctors, it may be useful for physicians to adopt a mutual means of interacting with their patients, extending so far as to implement shared decision-making strategies during medical encounters with geriatric patients—strategies that reflect the goals of patient-centred care.

Stewart et al.’s frequently cited model of patient-centred care emphasizes the following practices for enhancing interactions between patients and physicians: exploring both the disease and illness experience (i.e. understanding patients’ experiences of illness within their life context as well as recognizing the disease symptoms through a medical lens); seeing the patient as a whole person and acknowledging their life context, living situation, etc.; finding common ground regarding management of illness; incorporating prevention and health promotion strategies when dealing with the illness; enhancing the doctor-patient relationship; and being realistic (Hildebrand, 2007). Patient-centred care therefore focuses on 4 dimensions of illness experience:
the patient’s thoughts on what is wrong, their feelings and fears about the illness, the impact of the illness on their functioning, and patient ideas on what should be done (Hildebrand, 2007).

Shared decision-making works as a tool to enhance patient-centred care by providing specific steps that help involve patients in decisions about their care. These steps include: 1. Clarifying the decision(s) needing to be made; 2. Outlining the available options; 3. Informing the patient of the potential risks and benefits of treatment options; 4. Exploring the patient’s goals, concerns, and values; and 5. Determining which treatment option best coincides with the patient’s values and health goals (Lally & Tullo, 2012).

As mentioned in many of the studies assessed, patients want detailed health information that is explained using comprehensible language. They prefer to be offered treatment choices by their physicians and they also want physicians who see them as unique individuals with unique illness experiences. Patients indicated wanting and appreciating physicians who listened to them and took into account their views and preferences. They want physicians who appear interested in creating and maintaining a positive and comfortable long-term relationship. They also want physicians who are supportive of, and who facilitate, patient involvement in healthcare decisions. Patients in this study can therefore be said to desire a mutual mode of interaction with their physicians and patient-centred care that implements some or all aspects of shared decision-making strategies.

**Limitations of Study**

One limitation of this study is the lack of ethnic and socio-economic diversity represented by the 16 synthesized studies. While some of the studies did include interviews and focus groups with geriatric patients from different income and educational levels, most interviewed patients that had a high-school to college/university education and that were from middle-to-high income...
backgrounds. Most of the studies also failed to include interviews with geriatric patients from ethnically-diverse backgrounds. Further research with patients from these missing socio-cultural and economic contexts would therefore be useful for painting a more comprehensive picture of the needs and wants of geriatric patients as a whole.

Another limitation of this study could be the fact that patients who are willing to take part in research studies might also be more assertive and willing to participate in interactions with their physicians. Thus, this study could potentially be less representative of the needs and wants of patients who are less apt to or desirous of participating in clinical encounters. However, the findings of this study do point to the need for physicians to base their interaction styles on the wants and needs of their patients. In so doing, physicians could still provide the care desired by patients who are less eager about participating in their healthcare.

Though some authors suggest that “themes and concepts elucidated through qualitative research methods can be transferred to other settings” (Teh et al., 2009, p.527), most within clinical practices would be apt to only see legitimate transferability derived from randomized control trials. Thus, the themes and concepts resulting from this study may or may not be transferrable to other settings. The number of patient views represented in this meta-synthesis may, however, provide a stronger basis from which to produce generalizations than single qualitative articles can provide on their own.

**Recommendations**

This study recommends that future research focus on (a) assessing the outcomes of implementing shared decision-making strategies and patient-centred care within physician-geriatric patient encounters (b) assessing the communication needs and desires of geriatric patients from lower socio-economic backgrounds and (c) assessing potential medical system
alterations (e.g. billing codes) to accommodate proper chronic and preventative care alongside acute care. Due to the rapidly increasing population of seniors in Canada, it is also recommended that medical schools further increase the amount of geriatrics content offered within their curriculum so that future physicians will be able to work with this heterogeneous population no matter what their specialization.

**Significance of Study**

This study brings together the views of over 1000 geriatric patients regarding their needs and wants with respect to communication with their physicians. The study contributes to the debate surrounding the use of patient-centred care, and it also provides a take-away tips and pointers sheet that brings together the suggestions of geriatric patients and the greater literature to help improve physicians’ communication with their geriatric patients.

As an extension of this research, this study also attempts to contribute to increasing geriatric content offered in undergraduate school of medicine curriculums by informing the creation of an interactive training module that will serve the purpose of providing medical students with insight into the perspectives of geriatric patients.¹

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¹ To access a copy of this training module, please contact Nicole Bedford at geriatricsedu@gmail.com
CHAPTER 7 - CONCLUSION

Effective communication in the doctor-patient relationship is an essential component to proper diagnosis and treatment (Gordon & Gerber, 2010). While a greater focus on improving doctor-patient communication needs to be addressed, nowhere is it more important than in interactions between geriatric patients and general practitioners. By attempting to understand the needs and wants of geriatric patients with respect to communication with their general practitioners, barriers and facilitators to communication have been identified that can be avoided or used during clinical encounters. As this study has demonstrated, patients want to participate in their healthcare. They want physicians who are able to provide them with detailed health information that is explained using comprehensible language. Patients want to receive treatment choices from their physicians and they also want physicians who take their unique illness experiences into account when recommending treatment plans. Patients value long-term relationships with their physicians in which trust can be built. Trust was seen as a major facilitator of communication in the doctor-patient encounter.

Barriers to communication identified in this study included authoritarian physician attitudes, patients withholding information, physicians appearing rushed during the clinical encounter, not having enough time during consultation, lack of physician continuity, and patients forgetting important health information due to cognitive decline.

The information derived from this study can serve to enhance physician-geriatric patient communication if taken into consideration during clinical encounters. If anything is to be remembered after reading this study, it is the fact that geriatric patients are a heterogeneous population who fall on a continuum regarding the types of communication practices they value and the amount of participation they want during interactions with their providers. If physicians
truly wish to enhance their interactions with geriatric patients, they need only ask their patients how they want to be involved.
Bibliography


Canadian Institute for Health Information. (2011). *Seniors and the health care system: What is the impact of multiple chronic conditions?*. Ottawa, ON, Canada: Canadian Institute for Health Information.


Gordon, H. S., & Gerber, B. S. (2010). What we've got here is a failure to communicate. *Journal of General Internal Medicine, 26*(2), 104-106.


Street, R.L. Jr., Gordon, H., & Haidet, P. (2007). Physicians’ communication and perceptions of patients: Is it how they look, how they talk, or is it just the doctor?. *Social Science and Medicine, 65*, 586-598.


## Appendix 1

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Expanders - Apply related words
Search modes - Search Screen
Boolean/Phrase - Advanced

EBSCOhost Interface - 35

Search Database - CINAHL

S2  S1

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EBSCOhost Interface - 60396

Search Database - CINAHL

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EBSCOhost Interface - 60396

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EBSCO Publishing Citation Format: APA (American Psychological Assoc.):
web.ebscohost.com.proxy.queensu.ca/ehost/delivery?sid=eed903f5-c897-4aad-8cde-1f0b5885eb...
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### Search History

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- Set 10: 587 results
- Set 9: 878 results
- Set 8: 214 results

**Search Criteria:**

- 

**Refined by:**

- Publication Years:
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    - AND Subject Areas:
      - GERIATRIC GERIATOLOGY OR HEALTH CARE SERVICES: SERVICES OR NURSING OR GENERAL INTERNAL MEDICINE OR ORTHOPEDIC OR SOCIAL SCIENCES OR OTHER TOPICS
      - OR EDUCATION EDUCATIONAL RESEARCH OR REHABILITATION OR MEDICAL INFORMATICS OR PHARMACOLOGY PHARMACY OR COMMUNICATION OR SOCIAL ISSUES
      - OR Countries/Territories:
        - USA OR CANADA

**Database Selection:**

- SCIENCE EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH Thesaurus All Years

**Lemmatisation:**

- On

**Additional Resources:**

- Help
Appendix 3

**Coding Categories:**

*Barriers to communication:*

- **Systemic** = a barrier to communication that is due to issues inherent in the overall medical and/or greater socio-cultural system (Western-world). These barriers are not the result of specific, individual, or isolated factors. If the structure, organization, or policies of a system were to change, they could alleviate the systemic problem
  - Time (billing codes don’t allow for longer medical encounters)
  - Acute structure (1-problem per visit)
  - Power inequality/asymmetry
  - Lack of continuity of care/multiple physicians
  - Physician trained to focus on disease, symptoms, etc/treats numbers, not person (e.g. treating someone’s BP based on theory/standard charts and not the person’s “regular”)

- **Physical** = a barrier to communication that is due to bodily or space-related complications on the part of the physician or the patient
  - Hearing loss
  - Cognitive decline
    - Forgetfulness
  - Vision loss
  - Physical disability (preventing patient from going to doctor)
  - Physical structuring of office-space
  - Low lighting
  - Proximity during communication
  - Use of computer

- **Attitudinal** = a perception, prejudice, desire or belief held by patient or physician that impedes communication
  - Ageist attitude (Patient or Physician)
  - Insensitivity
  - Fear of illness (Patient)
    - Not wanting diagnosis information
    - Not wanting prognosis information
  - Desire to abstain from participating
    - In decision-making (treatment)
    - Withholding information (regarding concerns, symptoms, etc)
    - Failure to ask questions (Patient)
  - Feeling powerless
    - Lack of knowledge
    - Unable to articulate/express
  - Patient’s belief that physician lacks interest in patient
  - Patient’s belief that physician is not caring
  - Physician authoritative, abrupt, superior attitude
  - Lack of trust (Patient or physician)
• Specific communication-related barriers = behaviours/actions that skew the transmission, translation, and/or understanding/comprehension of a message communicated either non-verbally or verbally, by the physician or patient.
  o Failure to provide adequate information (Physician)
  o Information provided is too complex/Use of medical jargon
  o Confusing non-verbal communication
  o Low literacy/education (Patient)
  o Prognosis not discussed
  o Failure to verify patient understanding
  o Failure to demonstrate respect (e.g. inappropriate forms of addressing patient)
  o Physician lack of information or knowledge regarding treatments/disease etc

Communication Facilitators
• Attitudinal = a perception, prejudice, belief or desire held by patient or physician that facilitates communication
  o Desire to participate (Patient)
  o Desire for health information (Patient)
  o Supportive of patient-involvement (Patient or physician)
  o Physician sees patient as an individual
  o Physician perceived to be caring
  o Open-mindedness
  o Patient feels heard
  o Avoidance of assumptions/stereotypes
  o Physician respects patient/Patient respects physician (not reveres as god)
  o Trust between patient & physician

• Specific communication-related facilitators = behaviours/actions that enhance the transmission, translation, and/or understanding/comprehension of a message communicated either non-verbally or verbally, by the physician or patient.
  o Patient asks questions/seeks knowledge/information
  o Physician ascertains patient understanding/encourages patient questions
  o Physician inquires about patient goals/seeks clarification/asks for patient preference
  o Physician expresses/explains opinions/reasoning
  o Use of tools/diagrams
  o Physician listens to patient
  o Physician provides clear information/Lay terminology
  o Patient is Honest/Provides information (symptoms/signs)
  o Patient Participates in decision-making/is assertive
  o Physician is competent (knows treatment and disease information)
  o Sense of humor/jokes
- Contextual = specific situational circumstances that enhance physician-patient communication
  - Longer consultation times
  - Continuity of care
  - Long-term/good relationship
  - Convenient access to healthcare provider (distance, physical access)
  - Prompt appointments
  - Use of companions
  - Good communication between providers
  - Physician knows patient history

*Tips, suggestions, pointers highlighted by patients for themselves or physicians (for the purpose of improving doctor-patient communication)*
Appendix 4

*Due to size, this section simply represents a sample of the coding chart for this research project.

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**Barriers to Communication**

Systemic = a barrier to communication that is due to issues inherent in the overall medical and/or greater socio-cultural system (Western-world). These are

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<td>X</td>
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</tr>
<tr>
<td>1 problem per visit</td>
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</tr>
<tr>
<td>power inequalities/asymmetry</td>
<td></td>
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</tr>
<tr>
<td>physician trained to focus on disease/block treatment</td>
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</tr>
<tr>
<td>physician lacking comms training</td>
<td>X</td>
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<tr>
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<td>X</td>
<td>X</td>
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</table>

**Physical = a barrier to communication that is due to bodily or space-related complications on the part of the physician or the patient**

<p>| hearing loss                                               | X   |                   |     |                   |     |
| cognitive decline (forgetfulness)                          | X   | (repeated often)  |     |                   |     |
| vision loss                                                | X   |                   |     |                   |     |
| Mobility difficulties (preventing patient from going to the doctor) | X   | (repeated often)  |     |                   |     |
| patient is very ill/chronic conditions                     | X   |                   |     |                   |     |
| physical structuring of office space/physical accessibility |     |                   |     |                   |     |
| Lack of transportation/parking/access/distance use of computer | X   | X                 |     |                   |     |</p>
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<tr>
<td>income levels</td>
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<tr>
<td>male vs female</td>
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<tr>
<td>Ethnicities</td>
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**Barriers to Communication**

Systemic = a barrier to communication e barriers are not the result of specific, individual, or isolated factors.

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<tr>
<th>Time (billing codes; not enough time during consultation)</th>
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<tr>
<td>lack of physician continuity (group practices, not knowing physician, having to see multiple specialists)</td>
<td>X</td>
<td>X (repeated often)</td>
</tr>
<tr>
<td>1 problem per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>power inequalities/asymmetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician trained to focus on disease/block treatment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>physician lacking empathy training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>lack of access to physicians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| overloaded practices/too long to wait for appt (in waiting room as well as time) | X | X |

**Physical = a barrier to communication that is due to bodily or space-related complications on the part of the physician or the patient**

<p>| hearing loss | X |
| cognitive decline (forgetfulness) | X | X | X |
| vision loss |  |
| mobility difficulties (preventing patient from going to the doctor) | X |
| patient is very ill/chronic conditions |  |
| physical structuring of office space/physical accessibility |  |
| lack of transportation/parking/access/distances | X |
| use of computer |  |
| Attitudinal = a perception, prejudice, desire or belief held by patient or physician that impedes communication |  |</p>
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<th>Category</th>
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<tbody>
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<td>80.3-95-92</td>
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<td>college</td>
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<td>male VS female</td>
<td>3:20</td>
<td>0:11</td>
<td>6:14</td>
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<td>Ethnicities</td>
<td>US: Black, white and hispanic groups</td>
<td>US</td>
<td>Canadian</td>
</tr>
<tr>
<td><strong>Barriers to Communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time (billing codes; not enough time during consultation)</td>
<td>X</td>
<td>X</td>
<td>X (lack of time to build relationship)</td>
</tr>
<tr>
<td>lack of physician continuity (group practices, not knowing physician, having to see multiple specialists)</td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>1 problem per visit</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>power inequalities/asymmetry</td>
<td></td>
<td></td>
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<tr>
<td>physician trained to focus on</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>disease/block treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>physician lacking comms training</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>lack of access to physicians</td>
<td>X (hard to find new GP)</td>
<td>X</td>
<td></td>
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<tr>
<td>overloaded practices/too long to wait for appt (in waiting room as well as time)</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td><strong>Physical = a barrier to communication</strong></td>
<td></td>
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</tr>
<tr>
<td>that is due to bodily or space-related complications on the part of the physician or the patient</td>
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</tr>
<tr>
<td>hearing loss</td>
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</tr>
<tr>
<td>cognitive decline (forgetfulness)</td>
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</tr>
<tr>
<td>vision loss</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mobility difficulties (preventing patient from going to the doctor)</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>patient is very ill/chronic conditions</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>physical structuring of office space/physical accessibility</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Lack of transportation/parking/access/distance</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Use of computer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Attitudinal = a perception, prejudice, desire or belief held by patient or physician that impedes communication</strong></td>
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### Category

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<td>mean age/age range</td>
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<td>male VS female</td>
<td>12:14</td>
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<tr>
<td>Ethnicities</td>
<td>US, white, nonwhite/hispanic</td>
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### Barriers to Communication

<table>
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<tr>
<th>Systemic = a barrier to communication</th>
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<tbody>
<tr>
<td>Time (billing codes; not enough time during consultation)</td>
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</tr>
<tr>
<td>lack of physician continuity (group practices, not knowing physician, having to see multiple specialists)</td>
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</tr>
<tr>
<td>1 problem per visit</td>
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<tr>
<td>power inequalities/asymmetry</td>
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<tr>
<td>physician trained to focus on disease/block treatment</td>
<td></td>
</tr>
<tr>
<td>physician lacking comms training</td>
<td></td>
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<tr>
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<tr>
<td>hearing loss</td>
<td>X (also express fear when can’t see GP during exams)</td>
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<tr>
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<tr>
<td>vision loss</td>
<td></td>
</tr>
<tr>
<td>mobility difficulties (preventing patient from going to the doctor)</td>
<td></td>
</tr>
<tr>
<td>patient is very ill/chronic conditions</td>
<td></td>
</tr>
<tr>
<td>physical structuring of office space/physical accessibility</td>
<td>X (can’t access via normal means like phone)</td>
</tr>
<tr>
<td>lack of transportation/parking/access/distance</td>
<td></td>
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<td>use of computer</td>
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<td>Attitudinal = a perception, prejudice, desire or belief held by patient or physician that impedes communication</td>
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<td>1 problem per visit</td>
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<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>physician trained to focus on disease/block treatment</td>
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<tr>
<td></td>
<td>physician lacking coeffs training</td>
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<td>lack of access to physicians</td>
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<td>Physical = a barrier to communication that is due to bodily or space-related complications on the part of the physician or the patient</td>
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<tr>
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<td>vision loss</td>
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<tr>
<td></td>
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<td></td>
<td>patient is very ill/chronic conditions</td>
</tr>
<tr>
<td></td>
<td>physical structuring of office space/physical accessibility</td>
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<td>Lack of transportation/parking/access/distance use of computer</td>
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<td>X = from third round of coding</td>
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<tr>
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<tr>
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<td>Systemic = a barrier to communication</td>
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<td>Time (billing codes; not enough time during consultation)</td>
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<td>Physical = a barrier to communication that is due to bodily or space-related complications on the part of the physician or the patient</td>
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<tr>
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<tr>
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<td></td>
</tr>
</tbody>
</table>
Appendix 5

Geriatric Interaction:
Tips and Pointers

First Encounter:
- Prior to first consultation, review medical records from all patient’s previous doctors
- Book double consultations for first encounters with new geriatric patients
- Request that patient bring a medications list (including non-prescription)
- Introduce yourself formally & address patient with Mr., Mrs., or Ms. unless otherwise instructed
- Use open-ended questioning to collect a thorough patient history
  - Ask about medical history, family medical history, & presenting problem
  - Ask about socio-economic factors (e.g. financial status, housing, activities of daily living, diet, etc.)
- Ascertain patient’s health goals & desired outcomes. Revisit semi-frequently throughout relationship
- Learn about the patient as a person & ask about life goals, values, etc.
- Determine how patient wishes to be involved in medical decision-making. Revisit in later visits.
- Tell the patient about yourself (personal and medical aspects)

Vision Loss:
- Avoid directional cues that rely on vision
- Give patient time to focus on you before speaking
- Approach patient from front whenever possible
- Use touch (orient attention, direct, etc.)
- Assist patient’s movement when necessary

Hearing Loss:
- Speak to patient’s good ear (ask which one it is)
- When necessary use amplification
- Rephrase rather than repeat
- Cue patient to listen (eye contact, touch, etc.)
- Speak at moderate pace & enunciate

Cognitive Decline:
- Reinroduce yourself
- Be calm, pleasant, & reminisce with patient
- Ask permission with each touch or step of exam
- Break information into manageable pieces
- Allow patient to process information & respond
- Provide extended teaching of new information

Working with Companions:
- Ask patient permission for caregiver to be present
- Provide opportunity to see patient privately
- Include all parties in the conversation
- Have caregiver & patient repeat instructions
- Be aware of caregiver stress
- Praise caregiver

General Tips & Pointers:
- Connect with patient socially
- Listen carefully
- Sit close, face patient, & make eye-contact
- Ensure good lighting & minimal background noise
- Use contrasting colours & large font for documents
- Be aware of sensory & functional impairments
- Use open-ended questioning
- Describe process as examination occurs
- Pursue patient-initiated topics
- Keep patient goals, values, context in mind
- Provide patients with treatment options
- Explain using clear language, adapted to patient’s education level
- Use diagrams to aid explanations
- Verify patient understanding by asking patient to explain/repeat information
- Write down instructions & next steps
- Encourage patient to ask questions
- Be non-judgemental & accept patient decisions
- Help patients become educated on conditions
- Be honest

Questions to ask:
What was the most memorable experience of your life?
What is your biggest health concern? What can I do for you today that will make you feel better? How do you want your family to be involved in your care? What do you think is wrong? Is there something you’d like to ask me?