Montana Geriatric Education Center

Patients as Partners

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MONTANA GERIATRIC EDUCATION CENTER
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Goal/Purpose

Improve health outcomes for older adults in rural Montana via increased knowledge of geriatric care and treatment of health problems by health professionals.

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- Completion of pre-test
- Reading of text
- Completion of post-test with at least 70% accuracy
- Completion of module evaluation

Contact Hours: 2

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Description of Module

Content

The Patients as Partners Module describes a six step approach to a collaborative model of the provider-patient relationship. Various methods for effective communication and special issues associated with older persons and persons of different ethnic backgrounds are included. Case studies with specific suggestions for providers are also provided.

Learning Objectives

After reading this module, the learner will be able to:

- List reasons to encourage patient participation in decision making.
- Describe a collaborative model of shared decision making.
- Describe ways that the clinician can incorporate shared decision making in his or her practice.
- Describe special issues in shared decision making with the elderly person and persons of different ethnic backgrounds.

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I. Patients as Partners

"Years ago, I took full credit when people became well; their recovery was testimony to my skill and knowledge as a physician… all the time I thought I was repairing, I was collaborating." Rachel Naomi Remen, M.D. *Kitchen Table Wisdom* (1997)

A. Introduction

The need for effective relationships and communication between clinician and patient has recently been the subject of professional and popular reports (Frampton & Guastello, 2010; McGreevey, 2006). Yet, it was not until 1954 that Korsch first wrote about the need to develop a method of "teaching the then-unusual concept that physician should treat the whole person, not just the problem" (quoted in Harding, 1993, p. 46). Korsch discovered this communication problem when she directed the pediatric outpatient department at the New York Hospital – Cornell Medical Center, where she observed that many families did not return after a first visit. When the families were surveyed, she found that parents felt that clinicians did not understand or had been insensitive to their problems. "Until we did some of this work, nobody really looked at whether communication made a difference. Certain patients were just thought to be uncooperative" (quoted in Harding, 1993, p. 50).

A number of researchers have explored these compliance issues. Segal (2008) reported that 30-40% of patients fail to follow preventative regimens; of patients taking long-term medications, 50% fail to adhere to their treatment plans. DiMatteo (2007) reported that 20-40% of patients are nonadherent to treatments; adherence has been found to have significant effects on treatment outcomes (DiMatteo, Giordani, Lepper, & Croghan, 2002).The general feeling among many clinicians is that when medical advice has science on its side, it only makes sense to expect compliance from patients; to refuse to comply with medical advice is irrational (Segal, 2008). However, patients have their own logic and perspective on the problem; for example, they may have been asked to follow advice that is outside their lifestyle or ability or they may not see a connection between their prescribed treatment and their medical problem (Segal, 2008; Young & Flowers, 2001). The only way the clinician will know and be able to

intervene in these issues to build trust and open a dialogue with patients and allow them the opportunity to express their concerns.

Sharing an interest in and communicating with patients as individuals, recognizing their unique histories, skills, abilities, and preferences, are essential for developing trust between clinicians and patients. To preserve patient safety, patients need to be comfortable enough to share information openly; they need to understand, agree to and cooperate in their treatment, and to be empowered enough to speak about potential or real medical errors and hazardous conditions (Asnani, 2009). Such an environment has been termed a “culture of safety” (McGreevey, 2006); that is, one in which preventing harm to patients is paramount. It involves all members of the health care team: executives, administrators, clinicians, and patients, all having respect and trust in each other, with the goal of patient safety and satisfaction.

Research suggests that when patients feel empowered to challenge a clinician about any aspect of their treatment, when they feel supported not only by the clinician but by the entire health care organization, they are more likely to comply with treatment and have better health outcomes (Beach et al., 2005; Coulter, 2002). Such concepts are also termed "family centered care" (Johnson et al., 2007). In addition, patients who are involved as partners in their care have been shown to develop better relationships with those that treat them (Epstein, Apler, & Quill, 2004; Kuzel et al., 2005), are less likely to sue their physicians if things go wrong (Rubin, 2004), and are in a position to help prevent errors from occurring in the first place (American Academy of Family Physicians, 2010; Asnani, 2009).

Imagine a scenario from the patient’s perspective: a female patient has been waiting for her male physician for 20 minutes. She is angry at his tardiness, knowing she will now be late returning to work, in addition to being in pain and worried about her symptoms. The physician walks into the room, looks at his watch, and looks down his nose over his reading glasses as the patient describes her symptoms and concerns. He then crosses his arms and interrupts the patient 20 seconds into her discussion of her pain (McGreevey, 2006).

On a scale of 1-10, how comfortable would this patient be in talking to her physician? How much confidence would she have that the physician is really listening and paying attention

to what she is saying? How much like an equal partner would she feel in her health care? What, if anything, should the physician have done differently?

There are a number of easy solutions that are recommended by the Professional Development and Education Center at the Risk Management and Patient Safety Institute (McGreevey, 2006):

- Apologize for being late as a sign of respect for the patient's time
- Not looking at one's watch, so as not to seem in a hurry
- Take off reading glasses, so as to not look down your nose at the patient
- Sit down to meet the patient at eye level in order to convey both interest and equality
- Uncrossing the arms which conveys openness to what the patient has to say.

Each clinician-patient encounter is an opportunity for both parties to communicate: to speak, to listen, to understand, and to respond appropriately to what the other has said. This communication is essential for patient satisfaction and patient safety (McGreevey, 2006). Yet, on average, clinicians listen to their patients for 18 to 23 seconds before interrupting (Li, Krysko, Desroches, & Deagle, 2004). According to Dyche and Swiderski (2005), the act of interrupting results in at least three things: (1) it stops the flow of information, increasing the chances that the clinician will miss something important that the patient would have revealed if allowed a little more time to speak; (2) it increases the likelihood of the patient ending the clinical interview with the phrase: "Oh, by the way doctor," also known as the "doorknob question;" and (3) interrupting the patient stops the two-way communication that a relationship needs to develop.

II. Including Patients as Partners: A Collaborative Model Approach

One of the basic elements of a collaborative relationship is encouraging patients to ask questions. Most patients have been made to feel that they have relinquished this right, yet they are all but required to answer almost any kind of question from the clinician (Katz, Jacobson, Veledar, & Kripalani, 2007; Roter & Hall, 2006). For many patients, asking questions is seen as the exclusive right of clinicians and other caregivers. One study revealed that more than half of

patient-talk in medical visits is giving information in response to the clinician's questions. Only 6% of the 20 minute average visit involves patients asking the clinician questions. Half of the time of the medical visit, the clinician is involved in doing things that do not even require the patient's presence (e.g., recording chart information) (Roter & Hall, 2006; Tabenkin, Goodwin, Zyzanski, Stange, & Medalie, 2004).

Clinicians may also need to make a special effort to emphasize that they want their patients to participate actively in the diagnosis phase of their relationship. In a typical relationship with patients, it has been the clinician who assumes the sole responsibility for making the diagnosis and patients traditionally have accepted this (Katz et al., 2007).

In a collaborative approach to diagnosis, the patient is an active participant in the diagnosis. Collaborative practitioners view their patients more holistically and are more person-focused than problem-focused. They have a goal of empowering their patients in an ongoing process of self-diagnosis. As a result, patients are more likely to feel satisfied through developing more control and less likely to feel dependent on the expert (Williams, Haskard, & DiMatteo, 2007). Patient-centered communication includes: information giving, psychosocial talk, and expressions of partnership which are associated with greater patient satisfaction and improved patient outcomes (Williams et al., 2007). In a collaborative relationship, physician and patient mutually participate to make decisions about what is causing the problem, what is concerning the patient, which among several alternatives should be the best treatment, what the patient must do to implement the treatment, how they will know if the treatment works, and so on.

It is widely understood by psychologists that relationships that are mutually satisfying and lasting are those in which the parties solving the problems end up with solutions that are mutually satisfying to both. The process is more likely to be effective when they employ a system of problem-solving that they both can follow. Such a system of collaborative medical decision making was originally put forth by Gordon and Edwards (1997; see also McCutcheon, Chanen, Fraser, Dew, & Brewer, 2007); it is a six step approach will now be explored.

A. Step 1: Defining the Problem

In this first step, the clinician invites the patient to define the problem as he or she experiences it: complaints, symptoms and feelings. The clinician explains that his or her role will involve listening and perhaps note-taking. The clinician responds to the patient with empathic listening (described in more detail, later in this module), asks for clarification when needed, keeps responsibility with the patient, avoids closed-ended questions and encourages full patient disclosure. Occasional open-ended questions may be used, such as "Is there anything else that you have experienced?," "Can you think of anything else that may be relevant?," or "Anything more you want to tell me?"

A physical exam then follows after an explanation of why it is necessary. During the process, the clinician describes what he or she is doing, why it is being done, and what is found. If a diagnosis is apparent, then the clinician shares the diagnosis with the patient and invites questions or reactions.

If the clinician thinks tests are needed to corroborate the initial diagnosis, the nature of the tests and what the patient has to do to participate is explained. After the test results are in, the clinician explains the results. If the diagnosis is that the patient has some specific disease, the clinician describes the disease, verbally and/or with pictures or diagrams. Questions, reactions and concerns are invited. The clinician listens attentively and with empathy, to show understanding and acceptance of the patient's feelings or concerns. The clinician may ask the patient to describe the diagnosis in his or her own terms so that the clinician is certain that the patient understands it.

B. Step 2: Generating Alternative Solutions

In this step, the clinician invites the patient's participation to generate possible solutions for correcting the medical problem as it was defined in Step 1. The clinician explains that neither individual should evaluate any of the solutions until the list is complete. Depending upon the diagnosis, several solutions might be generated from such alternatives as: no treatment at all, certain medications prescribed, more tests for further verification, referral to a specialist, surgery, obtaining a second opinion, complete rest and relaxation, a diet or exercise

regimen, counseling, physical therapy, removing the cause of stress, revision of personal habits, change in sleeping habits, reduction in working hours, and so on.

C. Step 3: Evaluating Alternative Solutions

When both the clinician and patient feel that they have exhausted all the alternative solutions generated in Step 2, the patient and clinician evaluate the solutions (if there was more than one). What are the pros and cons of each? What are the costs? What are the risks? Are there time constraints? Is the best solution a combination of two alternatives? What are the expected outcomes?

D. Step 4: Deciding on a Mutually Acceptable Solution

When all of the facts are exposed and the alternative solutions weighed and analyzed, some best solution becomes clear to both clinician and patient. The clinician must refrain from advocating for a particular solution, recognizing that if the patient does not freely agree to the solution that best meets his or her needs, chances are the solution will not be willingly or completely implemented. The clinician records the solution and checks with the patient as to the accuracy of the description.

E. Step 5: Implementing the Solution

The clinician now opens a discussion about what needs to be done to implement the solution. *Who* does *what* by *when* is a useful framework for making a plan of action. Preferably, each person's tasks should be put in writing. The clinician agrees to carry out certain tasks – such as obtaining a date for admission to the hospital, authorizing X-rays, writing prescriptions and so on. The patient agrees to carry out certain tasks – getting prescriptions filled, going for X-rays, taking the medication, using ice packs, checking blood pressure and so on.

F. Step 6: Evaluating the Effectiveness of the Solution

This final step is important but need not always be formalized. The patient may ask, "How will we know if our solution has solved the problem?," "How long do we have to wait?," "What do we do if the solution does not work?," "Are there tests to evaluate the effectiveness of our solution?" The clinician acknowledges these concerns, but the patient also deserves to be given the best information about such things as the criteria for success or failure, the odds of success, and when relief might be experienced. The patient should be encouraged to write or

phone to inform the clinician whether or not, or to what degree, their mutually determined treatment worked. They might agree on a date for a follow-up visit for feedback.

This six step problem solving method allows the patient to feel that they are an equal part of a team rather than a child being told what to do. More often than not, collaborative problem-solving produces higher quality solutions to problems and produces higher motivation to implement the decision.

III. Effective Communication Skills to Enhance the Collaborative Relationship

There are a number of communication skills that can be used to enhance the collaborative relationship. Of interest in the present context are Empathic Listening, Passive Listening, and Attending Behaviors which are discussed below.

A. Empathic Listening.

Empathic or Active listening can be characterized as critical listening with an added awareness of the other's emotional and physical state. For example, because it is the patient who made the decision to see the clinician, the patient should be invited to begin the first encounter: "Tell me what brought you here today;" "Where do you want to start?"

Active listening requires the listener to put aside his or her own thoughts and feelings for a moment, shutting out as completely as possible his or her own way of looking at the world, in order to understand the speaker's personal and unique thoughts and feelings. Active listening requires the listener to empathize with the speaker, momentarily to identify with the speaker, and enter into the speaker's reality. It communicates understanding and empathy. Empathy is *feeling with* another, as opposed to sympathy which is *feeling for* another. Empathizing with another can be facilitated by asking oneself, "If I were having this same experience, what would be my feelings, thoughts or reactions?" Empathic listening has been described as a receiving of another's experience rather than a projection of one's own feeling onto the other person (Coulehan, 2009).

It is also necessary to check on the accuracy of the listener's understanding of the message. In active listening checking back and having the patient repeat his or her understanding of the discussion prevents misunderstandings and provides evidence of accurate communication.

B. Passive Listening.

Saying nothing is an important skill that professional counselors use extensively with their patients. Passive listening can provide patients with time to think about what they are going to say next, and often encourages them to move from a "presenting problem" to a more basic problem. However, silence does have the limitation of not giving adequate proof to patients that they have been accurately understood (Coulehan, 2007). Passive listening can be made more interactive by inserting noncommittal acknowledgments such as "I see," "Uh-huh," and "Oh".

C. Attending Behaviors.

These are physical postures that convey the clinician's desire to get involved with, show interest in, and focus almost exclusively on what the patient is communicating. Attending is also one way of demonstrating caring. It can be characterized as "relaxed alertness." It usually involves the caregiver in a physical position of inclining his or her body toward the speaker, facing the person squarely at eye level, and taking a position at an appropriate distance from the patient. Being too distant physically can block communication; sitting or standing too close may cause discomfort. Professional counselors suggest the distance of about a yard. Skilled listeners typically nod or shake their head when touched deeply. The most critical component of attending is consistent eye contact, avoiding glancing around the room or at your watch, and avoiding keeping your eyes glued on your paper when taking notes. If you feel uncomfortable with intense eye contact, you might begin by focusing on the speaker's mouth – later on the eyes.

Understandably, clinicians may wonder how they can take notes during the interview if they are supposed to keep looking at the patient when he or she is relating the health history. There are a number of solutions. They might consider audiotaping the initial interview. Or when

they feel a need to make a note on something important the patient has said, they might say, "Let me make a note of that."

Positioning the caregiver on one side of a desk opposite the patient may seriously inhibit open and honest patient self-disclosure. Desks usually symbolize a position of authority and can promote dependency or fear of judgment. A common solution is to place a chair at the side of the desk or sitting next to the patient in front of the desk.

Experts in the field of communication report that as much as three-fourths of person-to-person communication is nonverbal (Cocksedge, 2009). The clinician, who keeps his or her attention on the patient, gives the perception that the patient's talk is wanted and that the clinician is really trying to understand what the patient is communicating, and that he or she cares about the patient.

Table 1: ***Practical Tips for Effective Patient –Clinician Communication****

Opening the Interview	"Before we begin. I'd like to take a few moments to get to know you" "Did you have any problems getting to the office today?" "Tell me about yourself"
Information Gathering	Allow the patient to describe his or her concerns without interruption and then ask, "What else?" until the patient finishes. Jointly prioritize concerns
Relationship Building	PEARLS mnemonic *P*artnership: "We are going to solve this problem together" *E*mpathy: "It sounds like you are experiencing a lot of pain." *A*pology: I'm sorry I've kept you waiting." *R*espect: "I admire your strength and courage." *L*egitimization: "Many people with this illness experience similar symptoms." *S*upport: "I will be here for you throughout your treatment."

Conveying Information (e.g., test results, treatment plans)	Ask the patient about his or her understanding of the problem, tests done, etc. Speak slowly with jargon free language when giving the patient his or her test results, diagnosis, etc. Ask about his or her understanding and feelings. The Health Literacy Module will examine these concerns in more detail.

*Compiled from Barrier, Li & Jensen, 2003; Mueller, Hook & Fleming, 2004

IV. Health Literacy and the Clinician- Patient Relationship

A common cause of patient's misunderstandings may be a failure to communicate on both sides. On the one hand, clinicians often fail to realize that not all patients 1) understand medical jargon, 2) have reading skills that allow them to read or understand forms on their own, 3) understand the oral explanations their clinician provides, or 4) really understand what they have agreed to when they sign consent forms. On the other hand, patients may fail to tell clinicians that they do not understand what they have read or heard, may not ask for help to interpret the required form, and may not always ask questions that would let clinicians know that further explanation is needed. If the cause of patients' misunderstandings is the failure to communicate clearly on both sides, then the solution must involve both sides. Because clinicians have more authority to control the communication within the patient-to-clinician relationship, it is up to the clinicians not only to communicate more clearly and simply with all patients, but to recognize that some patients need more, or different, types of communication to aid their understanding (McGreevey, 2006).

How can clinicians know who understands them and who does not, who has low literacy skills and who does not, and who would benefit if the clinician used a different approach to communicating? This may not be easy, because many patients tend to be good at covering up their deficiencies. Consider these statistics:

- As a group, the elderly are less educated than younger patients. In the 2000 US Census only 61% of adults over the age of 75 had at least a high school education and only 13% had higher than a bachelor's degree (US Census, 2004; Williams et al., 2007).
- Almost half of all adult Americans have limited literacy skills or worse. They have trouble reading signs and using transportation schedules, let alone understanding clinicians' oral and written explanations of disease, treatment, procedures, or surgery (Moore, 2004). Understanding and filling out forms may be an impossible task.
- The average patient on Medicaid reads at 5th grade level. These patients may struggle to read appointment slips, prescriptions, medication labels, physician's instructions, patient education material, and forms (Wilson, 2003).
- The average American reads at an 8th or 9th grade level. Medical forms are written at even higher levels than this; therefore, the average American would have trouble reading and understanding forms and documenting informed consent (Wilson, 2003).
- Even patients who have high literacy may have trouble reading and understanding complex, specialized medical terminology, especially when they are ill and grappling with unwelcome news and difficult choices (Moore, 2004; Wilson, 2003).

Even those who appear to understand the information being communicated may not truly understand. After agreeing to or receiving care, 18% to 45% of patients are unable to recall the major risks of surgery. Many cannot answer basic questions about the services or procedures they agreed to receive, 44% do not know the exact nature of their operation, and at least 60% do not read or understand the information contained in informed consent forms, despite having signed them. Half of all patients do not understand what their physicians have told them (Moore, 2004). Such patients are not truly informed about the choices they have made (Wu, Nishimi, Page-Lopez, & Kizer, 2005).

Communicating Clearly. To communicate effectively with patients, it is recommended that clinicians take the following steps:

- Communicate with all patients in simple language without jargon. Explain even commonly used medical terms such as *hypertension, terminal* and *malignant* because they are not familiar to everyone (Wu et al., 2005).

- Limit new concepts to no more than three per visit.
- Use pictures, graphics, real devices or other visual aids for demonstration.
- Ask questions with “how” and “what” to aid comprehension.
- Slow down and take the time to assess the patient’s health literacy skills and understanding.
- Assume the burden of clear communication by asking if the information or directions were clearly presented. For example, say, “Am I clear?” instead of, “Do you understand?” (Rudd & Anderson, 2006).
- Go over written materials with patients, discussing with them the nature and scope of the procedure covered by informed consent forms.
- Provide an interpreter or reader to assist patients with limited English proficiency, visual or hearing impairments, and low literacy skills.
- Encourage the patient to bring a family member or other advocate to help in the understanding of medical information.
- Some patients may benefit from bringing a tape recorder and recording the clinician-patient discussion, so that they can replay it when they have time to process the information.

V. Elderly Patients as Partners- Special Issues

By the year 2020, 53.7 million individuals over the age of 65 will be living in the US; by 2050 that number will be 82 million (US Census, 2000). The elderly are uniquely burdened with healthcare problems; an elderly person has, on average, 3 to 4 chronic illnesses and a nearly 20% annual risk of hospitalization (Jahnigen & Schrier, 1986; US Census, 2000). Because of these factors, the clinician is much more likely to work with individuals of this age group in his or practice.

Effective patient-clinician communication maximizes patient autonomy. Yet important ethical and medical issues are often not discussed. For example, advanced care planning and end of life issues with older adults are rarely addressed (Mueller et al., 2004).

The National Institute on Aging (n.d.) suggests establishing respect from the beginning of the relationship with an elderly patient by using formal terms of address such as Mr., Mrs., Ms., etc. Introduce yourself clearly. The clinician should show from the start that he or she accepts the patient and wants to hear his or her concerns.

The older adult often experiences anxiety when visiting a clinician. This can be reduced by asking friendly questions, such as "Do you have family nearby?" or "Are you active in the community?" It is important to avoid rushing older patients. The clinician should try to give them a few extra minutes to talk about their concerns. As with all patients, doing so will allow the clinician to gather important information and will lead to better cooperation with treatment, saving time in the long run.

Beware of the patient's tendency to minimize complaints that he or she does "not want to be a bother," or the patient's concern that he or she is taking up too much of the clinician's time. It is advantageous to speak slowly, clearly and in a normal tone to give patients more time to process what is being said. As mentioned earlier try not to interrupt patients, give them time to explain issues in their own words.

It is important to avoid medical jargon, particularly with the elderly. Use simple, common language and be willing to ask the patient if he or she understands what was just said. It often is helpful to introduce new information by first asking patients what they know about their illness and then building on that.

Assess vision, hearing, and memory problems that can affect communication and may need to be addressed. Face patients directly, at eye level, and keep hands away from the face when talking, so they can lip read or pick up visual cues from what is being said. The clinician should give clues when changing the subject such as pausing briefly, speaking a bit more loudly, gesturing toward what will be discussed, gently touching the patient, or asking a question. Make sure that the setting is adequately lit and there is enough light on the speaker's face. Ask whether the patient has brought and/ or is wearing the right eyeglasses. Handwritten instructions should be easy to read. Similarly, make sure the type is large enough and the typeface easy to read when using printed materials.

For many seniors, it is important the interviewer enunciate slowly and clearly. Often, seniors complain that so many people shout at them, and this is not generally helpful. Hearing loss is often related to pitch, that is, some individuals cannot hear high pitch. Thus they can hear a man's voice easier; others cannot distinguish low pitch, thus, they are better able to hear a female's voice. The interviewer should ask if they are speaking clearly.

Additionally a patient may not have memory deficits; however, it is important to remember a senior may be processing the information at a different rate than a younger person. For seniors with memory deficits, they can be quite adept in using compensatory skills, which may result in the interviewer being unaware the patient is not processing or tracking the information.

Although socialization problems are not common, social isolation is a significant issue for many older seniors. The elderly may particularly benefit by having family members or an advocate attend the appointment with them. However, it is crucial that the older adult be the primary person addressed. Similar to working with a translator, address the discussion to the patient, keeping in mind that he or she is the person that must make decisions and implement them.

VI. Patients as Partners - Cultural Considerations

"Data from the 1990 census reveal that the number of persons who speak a language other than English at home rose by 43 percent to 28.3 million. Of these, nearly 45 percent indicate they have trouble speaking English" (National Center for Cultural Competence, n.d., para. 3).

As the US develops a more diverse population, clinicians increasingly find themselves needing to communicate with individuals whose primary language is different than their own. Allowing extra time for these individuals is a good first step. Whenever possible work with a trained interpreter rather than trying to communicate through a patient's family or friends to preserve confidentiality. Ensure that the interpreter translates everything that is said rather than "editing" the conversation (American Academy of Family Physicians, 2007). Direct your eyes and speech to the patient rather than the interpreter. Working across cultures requires sensitivity to different beliefs about health and illness, religious issues and gender issues. "One

may not be able to be 'culturally competent' for all people, but your goal should be to remain 'culturally sensitive' in all situations" (American Academy of Family Physicians, 2007, p. 33).

While it is not possible to review all cultural differences and issues in this limited space, there are a few strategies to keep in mind from Young and Flowers (2001, p. 77):

- Tap into patients' belief systems and mental representations of illness.
- Identify values and negotiate the seemingly disparate logics that patients bring to the decision making process.
- Elicit patients' values concerning health care and medical treatment.
- Elicit and incorporate the stories that patients bring to the medical encounter.

VII. Patient-Provider Collaboration with American Indian Elders

One influence on the interaction between provider and patient is the cultural/ethnic backgrounds of both individuals. Culture is defined as the way of life of a population, including shared knowledge, beliefs, values, attitudes, rules of behavior, language, skills and world view among members of a given society (Bereknyei et al., 2008). An ethnic group is defined as people of the same race or nationality who share a distinctive culture (Webster's Online Dictionary, 2011). The study of the influence of culture and ethnic group on older persons and their relationship to health and health care is called ethnogeriatrics.

An important ethnic group in Montana is the American Indian (AI). For most elderly persons from American Indian groups, the terms Indian or American Indian would likely be appropriate. The term Native American sometimes connotes a political position that is associated with younger generations (American Geriatrics Society, 2004). While American Indians make up only 1% of the population nationally, they are over 6% of the population in Montana. Elderly American Indians are about 5% of the American Indian population in Montana (US Census, 2000). There are seven reservations in Montana including the Flathead, Blackfeet, Rocky Boy, Fort Belknap, Fort Peck, Crow, and Northern Cheyenne. Each tribe should be considered as different and generalizations across tribal cultures can be dangerous. Older American Indians in the United States are more likely to live in poverty, live with a

disability, and have lower education levels when compared to all older Americans. However, they are less likely to live alone (King & Yeo, 2008). Although most elderly men and women speak English well, others speak it as a second language. It would be well to assume that even those who are fluent in English may still want to discuss complex issues in their native language (American Geriatric Society, 2004).

When considering cultural influences, cohort experiences help the provider to understand the historical context of an individual's life. A cohort is a group of individuals born during a particular period. For example, American Indians who are currently 85 years or older were raised during the period when AI children were taken from their reservation homes and boarded in missionary schools. Thus this group is more likely to understand and read English and identify themselves as Christian than later AI cohorts. American Indians who are currently 75 to 84 also experienced boarding schools as well as the "forced assimilation" where AI were relocated to urban areas. This cohort also served in WWII. These older American Indians were already middle aged or older when the period of Indian activism of the 1960's and 1970's occurred. American Indians who are now young old (aged 65-74) were more exposed to this activism period (Yeo et al., 1998).

Much research indicates health disparities exist between ethnic minorities and the general population in the United States (Satcher & Pamies, 2006; Yeo, 2008). Diseases and conditions more prevalent in the American Indian population include diabetes, accidents, alcoholism, cervical cancer, kidney disease, liver disease, tuberculosis, rheumatoid arthritis, and higher rates of suicide than the majority culture (Sue & Sue, 2008). Most kinds of cancer and cerebrovascular disease are less prevalent (Yeo, 2008).

Health care disparities for minority elders may exist for several reasons. There may be actual physiological, clinical differences. Also, culture may affect health behaviors such as diet or exercise. Important for this module is the issue that patient-provider interaction may be affected by differences in preferences for healthcare and patient-provider communication (Oddone, Peterson, Weinberger,et al., 2002; Yeo, 2008). Ethnicity can affect the patient's behavior, the patient's cognitive and affective responses, the provider's beliefs about the

patient, and clinical and treatment decision making (Bereknyei et al., 2008). For example, culture can determine the type and amount of emotion displayed by the patient and preferences for certain modes of non-verbal communication. More specifically, culture can affect elders' perceptions of their illness, expectation of providers, beliefs about health and health promotion, use of alternative health care, spiritual influences on health, family caregiving, use of non-family care, use of advance directives, and end of life care (American Geriatrics Society, 2004; Yeo, 2008).

Elderly Indians often integrate traditional concepts such as interaction with nature, balance, and harmony with biomedical models. Health and disease are believed to involve the need to maintain or regain a sense of coherence with self, nature, and others, such as family (which is variably defined), friends, and community. The restoration of balance is achieved through rituals, personal intent, and herbal remedies. The intent on the part of the healer to do good is also considered to be an important component of healing (American Geriatric Society, 2004).

Decision making is often done in a family unit that includes people outside the immediate nuclear family. Decision making for elderly men and women may be difficult when person(s) authorized under traditional structures to make decisions for the elder live elsewhere, which has become common with urban relocation and fewer people on reservations (American Geriatric Society, 2004).

Honesty on the part of the clinician is highly valued, as is care in obtaining consent for treatment. These issues are best understood in the context of the historical experience of a population that has experienced genocidal policies at times and still encounters suboptimal treatment in some health care settings (American Geriatric Society, 2004; Satcher & Pamies, 2006). However, being honest does not suggest the need to be aggressively direct in delivering bad news. Honest directness may be prized. One can talk about "a growth" rather than "cancer" and convey that biomedical practice has reached the limits of its ability to cure without making a statement about incurability. The need to convey prognosis honestly should be met while still conveying hopefulness. Predictions of life expectancy in the absence of

imminent death may be regarded as ill intentioned or in some way contributing to death (American Geriatric Society, 2004).

While it is important to consider cultural and historical background of both the patient and provider, the interaction and communication between patient and provider must be respectful and responsive to the individual preferences and experiences of the patient. It is important not to "stereotype", but to be sensitive to possible influences of cultural and ethnic background.

VIII. Summary

This module has explored issues and methods relating to collaborating with your patients in order to bring about a safe environment and to encourage shared decision making and increased treatment compliance. Empathic listening was discussed along with nonverbal methods to communicate effectively, such as working with personal space and showing attentiveness. Concerns related to health care literacy were examined, such as decreasing the use of jargon, reviewing information verbally, and checking on patient comprehension. Special issues of older adults were discussed, such as visual, hearing and memory impairment and some strategies in coping with them were listed. Finally, a caution was given to be aware of cultural differences in health care expectations and views. Following are two case examples.

A. Case Example 1

Nursing/Social Work/Pharmacist Case Example:

As you read the following case example, consider 1) ways that clinicians helped create good communication and a collaborative relationship; 2) ways the clinicians could have improved the relationships with the patient; and 3) cultural considerations specific to this American Indian patient.

Mrs. Johnson is a 65 year old widowed American Indian woman living on the reservation in Southwestern Montana. She has recently been diagnosed with Type 2 diabetes. She also has chronic hypertension and is overweight. Mrs. Johnson is referred to the diabetes management program to assist her in learning about management and self care of diabetes.

Mrs. Johnson's hypertension has been well controlled with lisinopril 20 mg daily. She understands the importance of her anti-hypertensive medication and consistently takes it as prescribed. Mrs. Johnson has been prescribed metformin 500 mg twice a day to manage her Type 2 diabetes. This is a new medication for her and she initially meets with the pharmacist for education about her medication regimen.

Pharmacist discussion

The pharmacist visits with Mrs. Johnson to obtain a complete medication history to determine what other medications she is taking, in addition to the lisinopril. The pharmacist learns that Mrs. Johnson is also taking a multiple vitamin, calcium and Vitamin D, and ibuprofen three times a day for arthritis pain. Allergy history and any prior adverse drug reactions are also documented; Mrs. Johnson does have a history of hives and swelling with penicillin. Social history, including tobacco and alcohol use, are also documented. The medication history is provided to Mrs. Johnson's physician, with a note that ibuprofen, a NSAID, may compromise renal function in older individuals and may worsen blood pressure control, particularly when administered with an ACE inhibitor (lisinopril). The physician asks the pharmacist to advise Mrs. Johnson to discontinue the ibuprofen, to try using acetaminophen (Tylenol) to control the arthritis pain, and to return to clinic if it doesn't provide adequate pain control. The pharmacist promises to call Mrs. Johnson in one week to see how the Tylenol is working for her.

The pharmacist visits with Mrs. Johnson about metformin, her new medication for diabetes. The pharmacist explains that metformin acts to lower the blood sugar and make her own insulin work better. It is often associated with weight loss in diabetics taking it, which may help Mrs. Johnson achieve her goal of weight loss. Learning that Mrs. Johnson does eat three meals a day, she is encouraged to take the medication with her morning and evening meals, to reduce the possibility of stomach upset. Common side effects include nausea, vomiting and diarrhea; if she experiences any of these for more than a week or if they are severe, she should notify the pharmacist or physician. Other side effects include weakness and headache. Having learned that Mrs. Johnson does drink alcohol on special occasions, the pharmacist cautions Mrs. Johnson about excessive use of alcohol, as it increases the risk of more serious side effects with metformin. The pharmacist and Mrs. Johnson review her schedule for checking her blood

sugars; she should start to see improvement from the metformin within a week and should report those results on her next clinic visit. She agrees to return to the clinic for another HgbA1c test in 3 months to check her progress in lowering her blood sugar.

Mrs. Johnson does express concern about the cost of new medication, but similarly to her lisinopril, it is available generically and will be covered by Tribal Health.

Nursing discussion

Mrs. Johnson then meets with the nurse to review her current HgbA1C results and to discuss diet, exercise needs and glucose monitoring. The nurse asks Mrs. Johnson to describe her daily routine of activity and requests information about forms of exercise that Mrs. Johnson regularly engages in. She learns that Mrs. Johnson routinely gardens and takes care of her yard but does not complete activities that improve cardiovascular fitness. She also determines that resources such as gyms or recreation centers are not available within a reasonable distance on the reservation. Mrs. Johnson does express that she enjoys walking, however, and together the nurse and patient develop walking goals that the patient believes she can meet.

The nurse and Mrs. Johnson discuss her meal patterns and dietary intake. The nurse makes suggestions regarding changes in methods of cooking and food choices that will decrease the overall fat and caloric count of regularly prepared meals. Mrs. Johnson asks for clarification about use of sugar in her diet and also asks about losing weight. Together the nurse and patient explore Mrs. Johnson's goals for weight loss and how that will improve her diabetic control. The nurse also provides Mrs. Johnson with information about her current HgbA1C results and they discuss glucose monitoring. Mrs. Johnson successfully demonstrates how to check her blood glucose and agrees to try to check her glucose in the morning and evening before meals.

Mrs. Johnson expresses concern about access to fresh fruits and vegetables as well as financial concerns related to purchase of food and medication. She reports that getting to the clinic is difficult due to lack of a car and dependence on relatives to drive her to appointments as well as the distance she must travel. The social worker at the diabetes management clinic explores these issues with the client to determine options for resources.

Social worker discussion

In meeting with Mrs. Johnson, the social worker explains her role in meeting with Mrs. Johnson, i.e., discussing her goals, identifying barriers/roadblocks which might prevent or impede her progress, brainstorming ideas and sharing information on resources and options which Mrs. Johnson may consider. The social worker asks Mrs. Johnson to discuss her goals she has developed having met with the pharmacist and the nurse. Mrs. Johnson expresses confidence in understanding her medications, and she is excited about trying to follow the recommended ADA diet.

Mrs. Johnson identifies concerns of being able to afford medications and supplies for her diabetes. The social worker reviews with Mrs. Johnson the avenues she currently uses to obtain her medications, learning Mrs. Johnson is able to obtain most of her medications through Tribal Health. Mrs. Johnson is willing to phone the Health Center to learn if her new medications will be available. Learning Mrs. Johnson has not enrolled in a Medicare Part D prescription plan, nor does she have a computer, the social worker offers to assist Mrs. Johnson in enrolling in a Medicare Part D Prescription plan to which Mrs. Johnson agrees. They complete the application process together. The social worker further explains other options such as Montana Big Sky Rx program and the pharmaceutical companies' Patient Assistance Programs if the cost of her medications is not covered in the future.

Mrs. Johnson identifies difficulty in getting to the appointments due to lack of a car and needing to rely on relatives to provide transportation, as well as to pay for gas. Through brainstorming a variety of options, Mrs. Johnson prioritizes her options as: 1) contacting Tribal Health to learn of the community van schedule, and arrange her appointments on the day of the van trip; 2) offer to organize a car pool with other individuals who come to the clinic in order to create a rotating schedule and share cost.

The social worker and Mrs. Johnson explore her concerns about being able to purchase the types of food recommended on the diet. The social worker learns Mrs. Johnson enjoys gardening and is agreeable to exploring ways to swap produce with other community members. With regard to Mrs. Johnson's concerns about being able to afford fresh fruits and vegetables and being able to purchase food, the social worker provides eligibility requirements and contact

information regarding the Area Office on Aging Farmer's Market coupon program, as well as information on the local food commodities program. Additionally, the social worker shares with Mrs. Johnson income eligibility guidelines for food stamps, resulting in Mrs. Johnson agreeing to complete an application. She reports she is able to complete this task without assistance.

The social worker agrees to contact Mrs. Johnson via phone in one week to provide additional support if needed.

Summary:

Nursing Discussion:

The nurse engaged the patient in discussing her normal routine of activities and meals to incorporate information that the patient could relate to current activities. The nurse also encouraged the patient to identify her own goals for weight loss and exercise to be certain that these goals were relevant and had meaning for the patient. While the patient did identify some barriers to being able to make changes in her diet, further discussion could have also explored additional barriers that the patient might experience in meeting diet, exercise and glucose monitoring goals and ways that the patient can overcome those barriers. Helping the patient to write down her goals and being certain that they are described in measurable terms that will allow the patient to experience early success is another important step in the collaborative process of chronic disease management and self-care. In addition, the nurse should be aware of cultural considerations surrounding food selection and preparation and encourage choices that respect the patient's American Indian heritage.

Pharmacist discussion:

The pharmacist obtained a complete medication history from the patient, including the use of nonprescription medications. In addition, the allergy history and use of social drugs was documented. The use of herbals, dietary supplements, and home remedies should also be documented. Problems encountered in the medication history were communicated to the physician, resulting in recommendations for change in nonprescription drug use. Follow up should be provided by the health care team to make sure that the change in analgesics does

control her arthritic pain. Counseling on the new medication, metformin, was provided to cover the major points of how it works, how to take it, and what to expect. Emphasis should be put on what to do if side effects do occur, so that the patient doesn't just stop the metformin. The patient should be encouraged to monitor her progress with the drug, both in terms of blood sugar control and weight loss.

Social Worker Discussion

The social worker facilitated good communication by sharing the social worker role and outlining how the social worker might be of assistance. The social worker encouraged collaboration in asking Mrs. Johnson to define her concerns, and approaching Mrs. Johnson as a partner in defining solution options and encouraging her to make choices/decisions. The social worker provided specific information about community resources, offered assistance, encouraged Mrs. Johnson to make choices, and fostered Mrs. Johnson's independence. The social worker might have encouraged Mrs. Johnson to explore with the nurse ways in which suggested food items could be substituted on the diet.

B. Case Example 2

Rehab Case Example:

As you read through the case example, think of 1) ways that the clinicians helped create good communication and a collaborative relationship; 2) ways the clinicians could have improved the relationship with the patient.

Mr. Jones, an 80 year old former construction contractor, had intermittent pain in his right shoulder for several years. He is now retired in the small community of Poplar, Montana. His physician in Glasgow diagnosed the problem as a partial rotator cuff tear (partial tear of the muscles surrounding the shoulder joint). Mr. Jones also has mild heart failure which is controlled by enalapril 5 mg. b.i.d. (ACE inhibitor) and metaprolol 50 mg. b.i.d.(beta blocker).

Given the options of surgery in Miles City versus a strengthening program in physical therapy, Mr. Jones chose to start with the strengthening program. The physical therapist in Glasgow and Mr. Jones reviewed his hobbies and recreational activities to determine his desired level of activity and strength needed. Together they determined that Mr. Jones would

need to complete a series of six sessions of strengthening and flexibility exercises under the supervision of the therapist before exploring additional options. Mr. Jones attended most of his therapy sessions and, after several weeks; he was started on a home and gym program. He received a written program of exercises strengthening the rotator cuff muscles, flexibility of shoulder elevation and rotation, and recommendations for general fitness. His level of shoulder pain free activity increased.

Unfortunately, six months later, Mr. Jones fell from a step ladder onto his right shoulder. After the accident he could not lift his right arm above his shoulder. His options at this time included reducing his activity level or having a surgical repair of a torn rotator cuff. Mr. Jones chose a surgical repair. After the surgery Mr. Jones returned home and restarted his physical therapy program with the assistance of a physical therapist visiting from the local home health agency. In addition, Mr. Jones received skilled nursing services while homebound to help him with pain management and his activities of daily living (ADLs). The physical therapist and nurse collaborated with Mr. Jones to develop an exercise program that would help him regain mobility while also increasing his level of independence in ADLs. Mr. Jones early program emphasized massage for pain and flexibility, gentle shoulder flexibility and isometric exercises. He later progressed to strengthening exercises within limited range.

In addition, they explored the best options for pain management that included use of a mild narcotic, hydrocodone 5 mg with acetaminophen 500 mg. The nurse was aware that the use of the narcotic, as well as a more sedentary activity level immediately after surgery, could lead to constipation. The nurse assessed Mr. Jones' normal bowel habits that existed prior to his surgery as well as his current bowel habits. Together they discussed options for managing possible constipation as a side effect of his narcotic use. Options they explored included intermittent use of a laxative such as Milk of Magnesia™, increasing his intake of fiber through fruits and vegetables, or use of prune juice on a daily basis. Mr. Jones decided that he would prefer to try using prune juice and then explore other options if that was not effective.

Mr. Jones continued to manage his mild heart failure without additional medications. The nurse did discuss with him the need to monitor his weight on a daily basis to determine fluid gain that would impact his heart function. In addition, Mr. Jones and the nurse discussed

his sodium intake and cooking habits as these would impact fluid retention. They discussed his normal eating patterns and possible options for minimizing his sodium, or salt, intake. Mr. Jones learned that many of the canned and processed foods he had been eating were high in sodium. He and the nurse discussed ways that he could continue to prepare his meals using low sodium options of these same foods or, when possible, removing the fluid from canned vegetables and reheating them in plain tap water to remove excess sodium.

He slowly developed increased strength and flexibility in his right arm and shoulder, allowing him to begin driving to physical therapy in Glasgow and resulting in his discharge from home health services.

One day he came to physical therapy complaining of increased swelling in his feet and a mild cough. Mr. Jones was referred back to his physician to check the status of his heart problem. His physician adjusted his medications, increasing the enalapril to 10 mg. b.i.d. and the metoprolol to 100 mg. b.i.d. and recommended a heart failure clinic at the hospital in Miles City supervised by a pharmacist. On his initial visit to the heart failure clinic, the pharmacist did a complete medication history. In addition to enalapril 10 mg. b.i.d. and metoprolol 100 mg. b.i.d., Mr. Jones was also on l-thyroxine 0.2 mg. daily for hypothyroidism and a multiple vitamin with minerals daily. He had tapered his use of the hydrocodone 5 mg. with acetaminophen 500 mg. to less than once a week, in part because it made him drowsy when he took it. He had recently had a flare up of his osteoarthritis in his knees and had started taking ibuprofen 200 mg. 2 tablets t.i.d., which had been recommended for similar pain in the past (5 – 10 years ago). The ibuprofen had upset his stomach so he had been using Alka-Seltzer two to three times a day for GI upset.

The use of ibuprofen and Alka-Seltzer pose two potential problems that could be exacerbating Mr. Jones' congestive heart failure. Ibuprofen is a nonsteroidal anti-inflammatory that is effective for pain and fever, but does have renal side effects, especially in the elderly. Other risk factors include congestive heart failure and the use of ACE inhibitors. The renal effects can lead to increased blood pressure and fluid retention, the latter being of concern in CHF. Additionally, NSAID use in the elderly is associated with gastric upset, ulceration and bleeding. Mr. Jones was experiencing nausea and GI discomfort with the ibuprofen, which he

was treating with Alka-Seltzer. Unfortunately, Alka-Seltzer contains a large amount of sodium (2 g. sodium bicarbonate per tablet) which would cause further fluid retention and edema. In addition, Alka-Seltzer contains 325 mg. aspirin per tablet, adding to the renal and gastric side effects of the ibuprofen.

After checking to make sure that Mr. Jones wasn't taking any other medications containing acetaminophen (other than the occasional hydrocodone/acetaminophen analgesic), the pharmacist suggested a trial of acetaminophen 500 mg. q.i.d. for a week to see if it would relieve the knee pain. If it wasn't effective, he advised Mr. Jones to contact his physician for a prescription analgesic.

The pharmacist also noted that Mr. Jones was not on a diuretic, which is commonly used in the treatment of symptomatic CHF. After ascertaining that Mr. Jones couldn't ever recall taking a diuretic or "water" pill, the pharmacist contacted the physician who ordered furosemide 20 mg. daily. He indicated that he would recheck Mr. Jones' electrolytes and renal function on his next office visit. Since Mr. Jones had never taken a diuretic, the pharmacist counseled him on the intended action of the drug, the need to take it early in the day, preferably early morning, and the expected increase in urine volume as a result of the diuresis. He also cautioned Mr. Jones to report any weakness or muscle cramping to his doctor, particularly if it occurred before his next office visit. Finally, he encouraged the patient to continue to check his weight daily and to note if his feet continued to swell or the cough returned.

The pharmacist also counseled Mr. Jones on all of his medications and helped him set up a schedule with times to take each one. He encouraged him to read OTC medication labels for warnings against use of the product in the presence of high blood pressure or heart failure. In addition to checking on the sodium content in canned foods, the pharmacist encouraged Mr. Jones to read medication labels for sodium content and to ask his hometown pharmacist for advice before starting on any new medications. Since it was difficult for Mr. Jones to attend the heart failure clinic in Miles City, the pharmacist referred him back to his local physician for follow-up.

In outpatient physical therapy, Mr. Jones continued a program of limited activities with the shoulder. He progressed from limited-range strengthening to full range activities. After 2 months, soft tissue mobilization was added to increase flexibility. While the pain gradually decreased, he had multiple ups and downs. He attended therapy 3 times a week; later this was decreased to twice a week. His strength and flexibility returned to near pre-surgery levels. He was discharged from physical therapy 4 months post surgery.

Summary:

Physician discussion

The physician presented several options. Hopefully, those options were all presented before a decision was made. Care needs to be taken to avoid or carefully explain complex anatomical and medical terminology such as rotator cuff, etc. One major problem for Mr. Jones is the lack of specialized orthopedic services in the small towns of Montana.

Nursing discussion

The nurse addressed the most pressing issues with the patient first, i.e. pain management and his ADLs. The nurse presented a number of different options for management of side effects of the narcotic and considered the patient's preferences for management of constipation. The nurse also addressed chronic disease management of heart failure with the patient by discussing diet and sodium intake as well as monitoring through weight measurements. Additional dietary changes may be needed in the future and providing resources (e.g. Meals on Wheels, Extension service dietician, hospital dietician) to the patient to choose from to address those would have been helpful. In addition, communication regarding the patient's diet could have been enhanced with using a more expansive approach to developing alternatives to his current diet so both the nurse and the patient could agree on mutually acceptable options to address his sodium intake. The nurse's communication regarding addressing issues of constipation was a better example of generating a broader list of alternatives for solving the problem. Chronic disease management of heart failure that is successful requires management of medications, diet, and exercise. As Mr. Jones developed

increased strength as well as improvement in his ADLs, both the therapist and the nurse could have addressed the issue of exercise to benefit Mr. Jones' management of his chronic heart failure. A full team discussion that engaged Mr. Jones in a problem solving approach to address his exercise needs would have been helpful to address this issue.

Therapist discussion

The therapist did a good job of considering the patient's needs and collaborating about the program. A written home program is good. It is important to include pictures; an exercise DVD might be available and more helpful. The presence of exercise facilities in a small town might be limited. If possible, visiting the gym with the patient would be better as the multitude of equipment makes its proper use difficult. Also, it would be important to investigate if the program was too time consuming and if travel was a problem. Perhaps, that is why Mr. Jones missed some appointments. Follow up appointments with a home program would be good to assess progress. A general fitness program should also be recommended for persons with controlled heart failure. The goal of such a program is to improve peripheral fitness so that less energy is required for daily activities. It would be important to work with Mr. Jones to design a program (such as walking) that he believes will work for him.

After surgery, driving to physical therapy can be a problem. The therapist also needs to listen carefully to the patient's pain complaints and needs. Modalities such as cold, alternating heat and cold, or TENS might help control pain. Working with the nurse regarding pain meds and associated problems is critical for success. Progress requires working together through the expected ups and downs of a rehab program. Patients should receive information on how to assess when they have exercised too much and to adjust their activities and pain control accordingly. The therapist should learn of other potential problems such as the knee through discussion with the patient. This problem should be evaluated for therapy treatment and referral if needed. After discharge from regular therapy, follow-up appointments or phone calls, perhaps once a month, should occur.

Pharmacist discussion

The pharmacist obtained a complete medication history on the patient and discovered that he was self-medicating with two over-the-counter medications that could be exacerbating his heart failure and putting him at risk for GI bleeding. Patients frequently don't consider OTC

drugs as “medications” that can interact with prescription drugs, worsen existing conditions and cause side effects. Documenting the use of all medications, prescription and OTC, along with herbals, dietary supplements, and home remedies is important, particularly in older patients who may be reluctant to share this information. The pharmacist also reviewed the current drug therapy and compared it to that recommended in evidence-based guidelines for the treatment of heart failure, thus identifying the need for a diuretic. Counseling the patient thoroughly on a new agent is always important, but even more so when timing of the dose is critical, the action of the drug (diuresis) may impact the patient’s daily activities, and side effects are common.

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