The purpose of this study was to identify communication styles and physician characteristics that correlate with improved patient adherence and satisfaction during geriatric healthcare interactions. A multiphase study design, incorporating the use of focus groups, socialization hours, educational seminars, and survey questionnaires, was used to discover the most effective methods for improving communication between physicians and their geriatric patients.

Elders favored direct, interactive verbal communication over alternative communication styles such as role-playing activities or the use of visual aids. Chi-square analyses showed that men desired more time with medical providers than women, who instead expressed a preference for more thorough explanations of disease processes. Further, men—and African American men in particular—sought medical advice from trusted friends more frequently than did women, who often preferred to solicit medical advice from family members.

The most significant barriers affecting physician-patient interaction were created by patients’ inflated expectations for consultation time and by physicians’ ineffective presentation styles. This study also reveals that physicians’ characteristics and patients’ gender and race also impacted the success of medical encounters.

(Key words: senior citizens, elderly, geriatric, patient satisfaction, patient adherence, communication styles, physician characteristics, physician-patient relationship)

The quality of the therapeutic relationship between physicians and patients can greatly affect patient adherence and treatment outcomes. This fact has decided implications for elderly populations. In the United States, 13% of the population is older than 65 years; one in eight of those is older than 85 years. Fink et al² assert that 40% of all patients in the United States are 65 years or older. Without proper training, physicians will be ill-equipped to handle the specific problems of their older patients.

Numerous researchers have identified problems unique to the elderly. Several studies note that older patients present with complicated medical conditions that are chronic and difficult to explain in a concise manner using non-technical terms. The rule of thumb for some geriatricians is to anticipate that for every decade after age 40, a patient will have one new chronic disease. Thus, physicians need to be increasingly aware of more than just the chief complaint.

Because of these factors, senior citizens are more likely to leave medical office visits with an abundance of confusing and sometimes conflicting information regarding disease processes and medications. The anxiety experienced by elders during physician office and hospital visits compounds this problem. If physicians do not adequately explain treatment protocols, older patients may feel confused and fail to seek clarification. Physicians need to focus on obtaining a comprehensive view of the patient’s problems as well as providing the patient with plainly worded, thorough explanations.

In the not-so-distant past, physicians were revered as the keepers of medical knowledge and were unquestioned in their diagnoses and recommended treatment modalities. Subsequently, to avoid being perceived as disrespectful or unintelligent, older patients may have remained passive during medical interactions.

However, modern medical encounters focus on a therapeutic contract, or relationship, in which patient and physician share equal responsibilities. This paradigm shift further reinforces the importance to both parties of developing a strong physician-patient rapport. Elders, more familiar with the “old school” of medicine, may be uncomfortable with this new medical model and may be reluctant—or unable—to take an active role in their healthcare decision making. In addition, seniors may not be current with the continual changes in healthcare terminology, technology, and treatment modalities. This knowledge gap further exacerbates communication problems.

Another serious communication barrier is the apparent negative attitude exhibited by some physicians toward senior citizens. Ageism, or prejudice against the elderly, is a problem...
that can compound the existing frustration geriatric patients experience during their healthcare interactions. Studies indicate that physicians provide less information and support, and are less egalitarian, less engaged, and less respectful with their older patients.9

Because of the complexity of their medical problems, elderly patients often require extra time and effort from their physicians. Research indicates that patient age is inversely related to visit length and treatment options.5,10 In the process of examining what is needed by senior citizens to improve their medical encounters, four research questions were used in this study to evaluate the needs of geriatric patients:

- Which presentation styles used by healthcare professionals are most effective in transmitting health-related information to elderly patients?
- From whom do seniors believe they receive the most reliable medical information?
- Which characteristics of healthcare professionals promote trust and build rapport with seniors?
- Do the elderly differ by gender and/or racial group in their preference for any single health information communication style?

Methods
A multiphase study was conducted during the summer of 1998 in Philadelphia, Pa, at four citywide senior centers. The participants were functionally independent, cognitively intact, and lived in the surrounding area. Forty subjects fully participated in the study through an intervention site while 120 participants from the three other centers completed surveys only. All participation was voluntary, and subjects were informed that the results gathered from their responses would not include any type of identifying information.

The study consisted of four parts, discussed in greater detail below:

- **Focus groups** were conducted to identify participants’ health concerns.
- **Socialization hours** were used to establish the rapport needed to interview participants about their healthcare encounters.
- **Educational seminars** were held to observe which presentation styles were most preferred by the elderly for communicating health and medical information.
- **Survey questionnaires** were distributed to identify whom seniors rely on for medical health information and to determine how elders perceive physicians (ie, character and information communication).

**Focus groups**
Four focus groups, each with ten elderly participants, were used to document participants’ medical histories and determine health concerns (Figure). Each tape-recorded session lasted approximately 1 hour. After each meeting, the tapes were transcribed and the transcriptions were reviewed to ensure accurate reporting of participants’ comments.

Topics of greatest concern included diabetes, osteoporosis, nutrition, arthritis, heat stroke, and heart disease. These participant-generated topics were used to develop educational seminars.

**Socialization hours**
Socialization hours were used to promote trust, build rapport between patients and researchers, and gain insight into preconceived notions held by seniors regarding healthcare. Seniors were informally asked which characteristics and styles they preferred in their physicians. Participants were also queried about what differentiated “excellent” physicians from all others.

For 6 weeks, 2 days per week were dedicated strictly to this task. Each recorded session lasted between 1 and 2 hours, and participants’ comments were documented in audiotapes and written notations. These comments were later compared with the survey results of the intervention sites to help determine congruency between subjective and objective results.

**Educational seminars**
Educational seminars were conducted 1 day per week to evaluate participants’ preferred method(s) of presentation for physicians communicating health-related information.

For 6 weeks, a different topic was discussed each week using a different presentation style; no single style was used more than once throughout the program (Table 1). All programs lasted approximately 30 minutes and included a topic introduction, activities related to that week’s presentation style, and a question-and-answer period.

---

**Figure. Examples of questions asked in focus groups**

- Who has given you the best information about [insert topic of the week]?
- What is the major problem with your doctor’s way of communicating with you?
- What is the best way your doctor could explain [insert topic of the week] to you?
- How was your understanding of [insert topic of the week] before the seminar?
- How was your understanding of [insert topic of the week] after the seminar?

---

Table 1...
to pose questions, the physician’s body language often indicated a lack of openness to these questions—as demonstrated by a lack of eye contact, moving toward the door before concluding the consultation, and a hesitance to touch the patient. These nonverbal actions gave the respondents a “rushed” and uneasy feeling, which caused further anxiety, tension, and forgetfulness.

Educational seminars and survey questionnaires
Patients’ preferred communication or presentation style—Educational seminars were conducted to evaluate by gender, race, and study site the most effective way of communicating health-related information to senior citizens (Table 3). Overall, the majority of all four surveyed groups (ie, men, women, African American, and Caucasian) chose lectures as their presentation style of choice (51%). Videotapes were also judged to be helpful in assisting comprehension (men, 21%; women, 20%; African Americans, 24%; and Caucasians, 19%).

Survey questionnaire
After each seminar, a multiple-choice questionnaire was distributed. The only change among weekly seminar questionnaires was the seminar topic itself. Similar questionnaires were distributed at three other senior centers in the Philadelphia area on a one-time basis. These surveys differed from the primary Philadelphia site surveys because only general (ie, not disease-specific) health inquiries were made. The non–primary site participants answered this survey but did not participate in the other educational aspects of the study.

The survey consisted of seven questions ranging from specific seminar topic–related concerns to general questions about physician-patient communication. The survey was formulated using information gathered from the focus groups and concentrated on the seniors’ most pressing concerns. Particular interest was paid to patients’ preferred presentation styles for communicating medical information, their perceived best sources of medical information, and their impressions of physicians’ major deficits regarding interpersonal interactions.

Data analysis
Surveys were evaluated to assess the perceived needs and wants of the study population in their medical interactions. Descriptive statistics were used to describe characteristics of the study population. Chi-square tests were created to evaluate possible preference differences by gender, race, and study site. An alpha level of .05 was set for accepting significant differences between comparison groups.

Results
The majority of the study’s participants were female (73%) and Caucasian (82%). Most seniors in the study were 65 to 74 years (44%) or 75 to 84 years (38%) with relatively few of 85 to 94 years (18%; Table 2).

Focus groups and socialization hours
Qualitative information collected in the focus group sessions and socialization hours emphasized a strong patient desire for personal interaction with and patience from physicians. Study participants placed a heavy emphasis on selecting physicians who were patient, caring, empathetic, and compassionate. Physicians who exhibited these traits promoted long-lasting relationships with their patients. Study participants further emphasized the need for establishing a feeling of comfort and trust with their physicians.

Physicians’ personal habits and their personal appearances were also crucial to how study participants responded to them. Overweight or unkempt physicians seemed to elicit opinions of considerably less influence over the study population.

It was repeatedly emphasized during the course of the study that physicians too often rush a patient visit and do not give their patients time to ask questions. It was also reported that when some physicians attempted to give patients a chance
Chi-square analysis showed no statistical difference in preferred presentation style between the intervention and non-intervention sites, gender, or racial group.

**Patients’ preferred sources for medical information**—Most respondents (Table 4) indicated that the most reliable source of health-related information they received was from their physicians (men, 56%; women, 62%; African Americans, 41%; Caucasians, 64%).

Chi-square testing indicated a significant difference ($P < .05$) for both gender and racial groups. Men were more apt (30%) to consult their friends regarding medical problems than were women (3%). Conversely, women were more likely (23%) to discuss their medical concerns with a family member than were men (12%). African Americans were more likely (34%) to consult friends about medical problems than were Caucasians (5%), who in turn were more likely (23%) than African Americans (7%) to seek health-related information from family members.

**Problems with physicians’ communication styles as perceived by patients**—Subjects reported several barriers to communication when interacting with physicians (Table 5). Many respondents reported the feeling that physicians “rush” through consultations (men, 40%; women, 36%; African Americans, 31%; Caucasians, 38%).

Participants also reported feeling that their physicians do not spend enough time with them (men, 42%; women, 28%; African Americans, 10%; Caucasians, 37%). Using words the patient does not understand was the third most significant complaint reported (19%).

Chi-square tests indicated significant differences between the two racial groups in the sample population ($P < .05$), but not between genders. Caucasian patients indicated that their physicians were not spending enough time with them during their visits. In contrast, the most important factor to African American patients was being treated with more dignity and respect.

**Comments**

The study results highlight the characteristics and communication styles common among physicians who are able to communicate successfully with senior citizens. The most consistently desired traits identified by study participants were patience, thoroughness, and clarity.

Additionally, the study indicates that physicians treating seniors are most effective when ensuring that patients’ office visits are participatory, comprehensive, and educational. Patients reported better adherence to treatment protocol when the attending physician is frank—yet remains empathetic and caring. Also, it is important to note that study participants often responded more strongly and intuitively to physicians’ nonverbal cues than to their spoken words.

Participants were most responsive to physicians who spent “sufficient” time explaining complicated modes of therapy in a simple and interactive manner. But how does one define “sufficient”? The study results show that senior citizens often have high expectations regarding consultation time with their physicians. Senior citizens did not specify the amount of time they thought was necessary; they provided only the general parameter of “the amount of time necessary” to properly address all outstanding issues and questions.

Managed care plans often exacerbate many physicians’ existing time constraints, requiring shorter consultation times to maximize the number of patient visits and minimize utilization and costs. Due to an increasing workload, heavy paperwork, and the demands of out-of-office visitations (eg, nursing facilities, hospices, home), mandated shorter consul-
Table 5
Patients' Perceived Problems with Physicians' Communication Style by Gender and Race

<table>
<thead>
<tr>
<th>Category</th>
<th>Gender, No. (%)</th>
<th>Race, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n = 43)</td>
<td>Female (n = 117)</td>
</tr>
<tr>
<td>Rushes patient</td>
<td>17 (40)</td>
<td>42 (36)</td>
</tr>
<tr>
<td>Talks down to patient</td>
<td>2 (5)</td>
<td>12 (10)</td>
</tr>
<tr>
<td>Hard to understand the doctor</td>
<td>4 (9)</td>
<td>27 (23)</td>
</tr>
<tr>
<td>Not enough time spent with patient</td>
<td>18 (42)</td>
<td>33 (28)</td>
</tr>
<tr>
<td>Other</td>
<td>2 (5)</td>
<td>3 (2)</td>
</tr>
</tbody>
</table>

*Percentages are rounded and are reported for each subgroup. Totals may not equal 100%.

Vieder et al • Original contribution

Table 4
Perceived Best Source of Information by Gender and Race

<table>
<thead>
<tr>
<th>Category</th>
<th>Gender, No. (%)</th>
<th>Race, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male (n = 43)</td>
<td>Female (n = 117)</td>
</tr>
<tr>
<td>Family member</td>
<td>5 (12)</td>
<td>27 (23)</td>
</tr>
<tr>
<td>Friend</td>
<td>13 (30)</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0 (0)</td>
<td>8 (7)</td>
</tr>
<tr>
<td>Physician</td>
<td>24 (56)</td>
<td>72 (62)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (2)</td>
<td>7 (6)</td>
</tr>
</tbody>
</table>

*Percentages are rounded and are reported for each subgroup. Totals may not equal 100%.

Ong et al have reported the importance of recognizing patients’ cultural differences and how these differences can affect patients’ perceptions of “good medical care.” Most notably, African Americans in the survey group report feeling an attitude of “disrespect” coming from medical personnel during consultations. This patient perception may contribute to the increased preference of many African Americans to seek medical advice from friends instead of healthcare professionals, as noted previously. A combination of psychosocial or sociodemographic variables may explain the preference of African American patients to consult friends about medical and healthcare issues rather than their physicians. The most significant variable leading African American patients to seek healthcare advice from friends, rather than from medical personnel, may be a lack of familiarity with navigating the usage of our healthcare system. Further studies need to be conducted to determine precisely why African Americans prefer consulting friends instead of physicians. If physicians hope to treat the medical problems of elders effectively, it is essential that they recognize and respond appropriately to each patient’s background.

The major limitation of the study was the varying degrees of complexity in the seminar topics. The effectiveness of each presentation style was determined based on the seniors’ abilities to understand and retain the information introduced during these educational seminars. Because of the wide spec-
trum of seminar topics and their varying degrees of complexity, a confounding factor existed in measuring the success of each presentation technique. To determine which presentation style yielded the maximal effectiveness, a different style was used for each seminar topic (Table 1). This technique circumvented the natural human ability to process information through repetition and increased familiarity.

Conclusion
If concerns raised by seniors during the course of patient consultations can be addressed directly and more accurately, better physician-patient interactions would result and better treatment could be delivered. Our findings suggest that physician-patient interpersonal skills training, specifically with regard to the geriatric demographic, needs to become a more prominent feature of modern medical education. This concept and the related skills need to be introduced in the first 2 years of medical school with an ongoing emphasis during clerkships and postgraduate medical training.

However, physicians cannot bear the weight of the problem alone. Insurance companies need to provide patients with clear and concise literature regarding standard patient treatment protocols. In addition, they should assist in educating patients on how to enhance communication skills with their healthcare providers so that medical care is optimized. Seniors themselves should also be encouraged to take a more active role in learning to navigate the healthcare system in an efficient and productive manner.

Inflated patient expectations about consultation length and ineffective physician communication styles create the most significant barriers in medical interactions with senior patients. Other factors, such as the physician’s personal characteristics and the patient’s gender and race, also play a large role in the overall success of healthcare encounters. An improved standard of healthcare for this population can be achieved only through a joint effort to bridge existing communication gaps.

Acknowledgments
The authors thank Melissa Herring, Ronald Klimberg, PhD; Jane Dunsha; Valerie Hamaday; and Eugene Mochan, DO, PhD, for their advice and support.

This paper won the student presentation prize at the 43rd Annual American Osteopathic Association Research Conference in San Francisco, Calif. The original abstract to this article was published in the September 1999 issue of JAOA.

References


