

FLEX CEUs



Communicating with Geriatric Patients



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Foreword

Good communication is an important part of the healing process.

Studies find that effective physician-patient communication has specific benefits: patients are more likely to adhere to treatment and have better outcomes, they express greater satisfaction with their treatment, and they are less likely to bring malpractice suits.

Research also shows that good communication is a teachable skill. Medical students who receive communication training improve dramatically, not only in communicating with patients, but also in assessing and building relationships with them. Time management skills also get better. Communication skill is now a core competency identified by the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS).

Learning effective communication techniques—and using them—may help you build more satisfying relationships with older patients and become even more skilled at managing their care.

Communicating with older patients involves special issues. For example:

- How can you effectively interact with patients facing multiple illnesses and/or hearing and vision impairments?
- What's the best way to approach sensitive topics such as driving privileges or assisted living?
- Are there ways to help older patients who are experiencing confusion or memory loss?

With questions like these in mind, the National Institute on Aging (NIA), part of the National Institutes of Health, developed this booklet.

Although referring to clinicians throughout the text, this booklet is intended for use by a range of professionals dealing directly with patients—physicians, physicians-in-training, nurse practitioners, nurses, physician assistants, and other health care professionals. The aim is to introduce and/or reinforce communication skills essential in caring for older patients and their families. *Talking With Your Older Patient: A Clinician's Handbook* offers practical techniques and approaches to help with diagnosis, promote treatment adherence, make more efficient use of clinicians' time, and increase patient and provider satisfaction.

Three points are important to remember:

- Stereotypes about aging and old age can lead patients and health professionals alike to dismiss or minimize problems as an inevitable part of aging. What we're learning from research is that aging alone does not cause illness and that growing older does not automatically mean having to live with pain and discomfort.
- Many of this booklet's suggestions may, at first glance, appear to be time-consuming, especially given the time constraints of most clinicians. However, an initial investment of time can lead to long-term gains for physicians and patients. Time-intensive practices need not be inefficient. You may get to know your older patient's life history over the course of several visits rather than trying to get it all in one session.
- Older patients are diverse and unique, just like your younger patients. You may see frail 60-year-olds and relatively healthy 80-year-olds. Your patients may be culturally diverse. Some may be quite active while others may be sedentary. The techniques offered here encourage you to view all older people as individuals who have a wide range of health care needs and questions.

Many physicians, nurses, researchers, and other health care professionals were generous in providing information and advice on making this edition of the *Clinician's Handbook* useful. The Institute is grateful for their thoughtful contributions.



Richard J. Hodes, M.D., Director
National Institute on Aging
National Institutes of Health

Considering Health Care Perceptions

The best way to learn what is and is not acceptable is to communicate directly with patients and caregivers.

“I’m 30 . . . until I look in the mirror.”

Mrs. Hill is an 85-year-old nursing home resident. She has lived in a facility since advanced heart disease made it impossible for her to live independently. Her adult children feel that life in a nursing home must be a nightmare. They want to do something, but they don’t know what. Moving her to one of their homes isn’t an option; visiting her makes them feel depressed. One day, her doctor chats with Mrs. Hill about life in the home. She tells him that this is one of the best times of her life—people prepare and deliver her meals, she has a comfortable room with a view of the gardens, and the place is very peaceful. Mrs. Hill is quite happy and has no desire to move.

For Mrs. Hill, a life her children find unacceptable is, in fact, just fine with her. What seems intolerable to a 40-year-old may actually be preferred by a 90-year-old.

In the past century, the nature of old age has changed dramatically. In the early 1900s, the average life expectancy was about 49 years—today, it is nearly 80 years. With longevity, however, comes the sobering news that older

people may live for years with one or more chronic, potentially disabling conditions. This means they will have an ongoing need for medical services.

No single characteristic describes an older patient. Each person has a different view of what it means to be old. A 68-year-old woman with an active consulting business is likely to deal with a visit to the doctor quite differently from her frail 88-year-old aunt who rarely ventures beyond her neighborhood.

The perspectives that follow are common among older people—and important to consider when talking with older patients.

Views of Physicians and Clinicians

In the past, older people have held doctors in high esteem and treated them with deference. This view may change over time as aging baby boomers are likely to take a more egalitarian and active approach to their own health care.

Today, many older people don't want to "waste the doctor's time" with concerns they think the clinician will deem unimportant. Patients sometimes worry that if they complain too much about minor issues, they won't be taken seriously later on. Or, they are afraid of the diagnosis or treatment. They may worry that the physician will recommend surgery or suggest costly diagnostic tests or medications.

Some patients do not ask questions for fear of seeming to challenge the clinician. On the other hand, some older people, having ample time and interest, will bring popular medical articles to the attention of their providers. This kind of active patient participation can provide an opportunity for communication.

Views of Aging

Ageism can work both ways. Doctors can make assumptions about their older patients. Older people may unwittingly assume the stereotypes of old age. Expectations regarding health diminish with age, sometimes realistically, but often not. Older people with treatable symptoms may dismiss their problems as an inevitable part of aging and not get medical care. As a result, they may

suffer needless discomfort and disability. Some may not even seek treatment for serious conditions.

The process of aging may be troubling for older adults. It can be especially hard for people who once bounced back quickly from an illness or were generally healthy. Experts observe that baby boomers bring different expectations, experiences, and preferences to aging than did previous generations. For instance, some boomers are likely to want to participate actively in health care treatments and decisions. They may also search the Internet for health information.

Values About Health

Although physicians typically focus primarily on diagnosing and treating disease, older people generally care most about maintaining the quality of their lives. They are not necessarily preoccupied with death. In fact, many older people are relatively accepting of the prospect of death and seek chiefly to make the most of their remaining years. Younger family members, who commonly must make life-and-death decisions when an older person is incapacitated, may be unaware of the patient's views and preferences.

In Summary

- ✓ Let older patients know that you welcome their questions and participation.
- ✓ Encourage older adults to voice their concerns.
- ✓ Be alert to barriers to communication about symptoms, such as fears about loss of independence or costs of diagnostic tests.
- ✓ Expect those in the baby boom generation to be more active participants in their health care.

Understanding Older Patients

What was once called “bedside manner” and considered a matter of etiquette and personal style has now been the subject of a large number of empirical studies. The results of these studies suggest that the interview is integral to the process and outcomes of medical care.

“Tell me more about how you spend your days.”

Although she complains of her loneliness and long days in front of the TV, Mrs. Klein refuses to participate in activities at the community senior center. “I’m not playing bingo with a bunch of old ladies,” she tells her doctor when he suggests she get out more. “You’ve mentioned how much you love to garden,” her doctor says. “The center has a garden club with a master gardener. One of my other patients says she loves it.” “I don’t want to hang around old people who have nothing better to do than compare health problems,” she says. “Why not give it a try?” her doctor asks. “You might find the members are pretty active gardeners.” Six months later, when she sees the doctor again, Mrs. Klein thanks him. She has joined the garden club and reports that the members all have green thumbs as well as being quite lively conversationalists. Better still, Mrs. Klein’s depressive symptoms seem improved.

Effective communication has practical benefits. It can:

- help prevent medical errors
- strengthen the patient-provider relationship
- make the most of limited interaction time
- lead to improved health outcomes

This chapter provides tips on how to communicate with older patients in ways that are respectful and informative.

Use Proper Form of Address

Establish respect right away by using formal language. As one patient said, “Don’t call me Edna, and I won’t call you Sonny.” You might ask your patient about preferred forms of address and how she or he would like to address you. Use Mr., Mrs., Ms., and so on. Avoid using familiar terms, like “dear” and “hon,” which tend to sound patronizing. Be sure to talk to your staff about the importance of being respectful to all of your patients, especially those who are older and perhaps used to more formal terms of address.

Make Older Patients Comfortable

Ask staff to make sure patients have a comfortable seat in the waiting room and help with filling out forms if necessary. Be aware that older patients may need to be escorted to and from exam rooms, offices, and the waiting area. Staff should check on them often if they have to wait long in the exam room.

Take a Few Moments to Establish Rapport

Introduce yourself clearly. Show from the start that you accept the patient and want to hear his or her concerns. If you are a consultant in a hospital setting, remember to explain your role or refresh the patient’s memory of it.

In the exam room, greet everyone and apologize for any delays. With new patients, try a few comments to promote rapport: “Are you from this area?” or “Do you have family nearby?” With established patients, friendly questions about their families or activities can relieve stress.

Try Not to Rush

Avoid hurrying older patients. Time spent discussing concerns will allow you to gather important information and may lead to improved cooperation and treatment adherence.

Feeling rushed leads people to believe that they are not being heard or understood. Be aware of the patient's own tendency to minimize complaints or to worry that he or she is taking too much of your time.

Avoid Interrupting

One study found that doctors, on average, interrupt patients within the first 18 seconds of the initial interview. Once interrupted, a patient is less likely to reveal all of his or her concerns. This means finding out what you need to know may require another visit or some follow-up phone calls.

Older people may have trouble following rapid-fire questioning or torrents of information. By speaking more slowly, you will give them time to process what is being asked or said. If you tend to speak quickly, especially if your accent is different from what your patients are used to hearing, try to slow down. This gives them time to take in and better understand what you are saying.

Use Active Listening Skills

Face the patient, maintain eye contact, and when he or she is talking, use frequent, brief responses, such as "okay," "I see," and "uh-huh." Active listening keeps the discussion focused and lets patients know you understand their concerns.

Demonstrate Empathy

Watch for opportunities to respond to patients' emotions, using phrases such as "That sounds difficult" or "I'm sorry you're facing this problem; I think we can work on it together." Studies show that empathy can be learned and practiced and that it adds less than a minute to the patient interview. It also has rewards in terms of patient satisfaction, understanding, and adherence to treatment.

For more information on active listening, contact:

American Academy on Communication in Healthcare

16020 Swingley Ridge Road, Suite 300
Chesterfield, MO 63017
636-449-5080
www.aachonline.org

This professional organization aims to improve physician-patient relationships and offers courses and publications on medical encounters and interviews.

Macy Initiative in Health Communication

Division of Primary Care
NYU School of Medicine
550 First Avenue
New York, NY 10016
212-263-3071
<http://macyinitiative.med.nyu.edu>

This initiative was a collaborative effort of three medical schools to identify and define critical communication skills needed by physicians. It developed competency-based curricula for medical students.

New England Research Institutes (NERI)

9 Galen Street
Watertown, MA 02472
617-923-7747
www.neriscience.com

NERI has designed a CME-accredited CD-ROM, *Communicating With Older Patients*, educating physicians on communication strategies to practice with older patients.

Avoid Jargon

Try not to assume that patients know medical terminology or a lot about their disease. Introduce necessary information by first asking patients what they know about their condition and building on that. Although some terms seem commonplace—MRIs, CAT scans, stress tests, and so on—some older patients may be unfamiliar with what each test really is. Check often to be sure that your patient understands what you are saying. You may want to spell or write down diagnoses or important terms to remember.

Reduce Barriers to Communication

Older adults often have sensory impairments that can affect communication. Vision and hearing problems need to be treated and accounted for in communication. Ask older patients when they last had vision and hearing exams.

Compensating for Hearing Deficits

Age-related hearing loss is common. About one-third of people between the ages of 65 and 75, and as many as half of those over the age of 75, have a hearing loss. Here are a few tips to make it easier to communicate with a person who has lost some hearing:

- Make sure your patient can hear you. Ask if the patient has a working hearing aid. Look at the auditory canal for the presence of excess earwax.
- Talk slowly and clearly in a normal tone. Shouting or speaking in a raised voice actually distorts language sounds and can give the impression of anger.
- Avoid using a high-pitched voice; it is hard to hear.
- Face the person directly, at eye level, so that he or she can lip-read or pick up visual clues.
- Keep your hands away from your face while talking, as this can hinder lip-reading ability.
- Be aware that background noises, such as whirring computers and office equipment, can mask what is being said.
- If your patient has difficulty with letters and numbers, give a context for them. For instance, say, “m’ as in Mary, ‘two’ as in twins, or ‘b’ as in boy.” Say each number separately, (e.g., “five, six” instead of “fifty-six”). Be especially careful with letters that sound alike (e.g., m and n, and b, c, d, e, t, and v).
- Keep a note pad handy so you can write what you are saying. Write out diagnoses and other important terms.
- Tell your patient when you are changing the subject. Give clues such as pausing briefly, speaking a bit more loudly, gesturing toward what will be discussed, gently touching the patient, or asking a question.

Compensating for Visual Deficits

Visual disorders become more common as people age. Here are some things you can do to help manage the difficulties caused by visual deficits:

- Make sure there is adequate lighting, including sufficient light on your face. Try to minimize glare.
- Check that your patient has brought and is wearing eyeglasses, if needed.
- Make sure that handwritten instructions are clear.
- When using printed materials, make sure the type is large enough and the typeface is easy to read. The following print size works well:

“This size is readable.”
- If your patient has trouble reading, consider alternatives such as tape recording instructions, providing large pictures or diagrams, or using aids such as specially configured pillboxes.

Be Careful About Language

Some words may have different meanings to older patients than to you or your peers. For example, the word “dementia” may connote insanity, and the word “cancer” may be considered a death sentence. Although you cannot anticipate every generational difference in language use, being aware of the possibility may help you to communicate more clearly. Use simple, common language and ask if clarification is needed. Offer to repeat or reword the information: *“I know this is complex; I’ll do my best to explain, but let me know if you have any questions or just want me to go over it again.”*

Low literacy or inability to read also may be a problem. Reading materials written at an easy reading level may help.

Ensure Understanding

Conclude the visit by making sure the patient understands:

- what the main health issue is
- what he or she needs to do about it
- why it is important to do it

One way to do this is the “teach-back method”—ask patients to say what they understand from the visit. Also, ask if there is anything that might keep the patient from carrying out the treatment plan.

In Summary

- ✓ Address the patient by last name, using the title the patient prefers (Mr., Ms., Mrs., etc.).
- ✓ Begin the interview with a few friendly questions not directly related to health.
- ✓ Don't rush, and try not to interrupt; speak slowly and give older patients a few extra minutes to talk about their concerns.
- ✓ Use active listening skills.
- ✓ Avoid jargon, use common language, and ask if clarification is needed, such as writing something down.
- ✓ Ask the patient to say what he or she understands about the problem and what needs to be done.

Obtaining the Medical History

When patients are older, obtaining a good history—including information on social circumstances and lifestyle as well as medical and family history—is crucial to sound health care.

“What brings you here today?”

Mr. Symonds has advanced lung disease and usually manages well with home oxygen. But, he’s been admitted to the emergency room three times in as many weeks, unable to breathe. The health team is puzzled because Mr. Symonds is taking his medications on schedule and, he says, using the oxygen. Finally, a home care nurse is sent to the Symonds’ house. She discovers that because of this winter’s bitter cold, Mr. Symonds has been running a kerosene heater in his kitchen. He does not use the oxygen and heater at the same time for fear of fire.

The varied needs of older patients may require different interviewing techniques. The following guidelines can help you to obtain a thorough history of current and past concerns, family history, medications, and socioeconomic situation. These suggestions are less time-consuming than they may appear. Some involve a single investment of time. Other health care professionals in the office or home may assist in gathering the information. You may want to get a detailed life and medical history as an ongoing part of older patients’ office visits and use each visit to add to and update information.

General Suggestions

You may need to be especially flexible when obtaining the medical history of older patients. Here are some strategies to make efficient use of your time and theirs:

- If feasible, try to gather preliminary data before the session. Request previous medical records, or if there is time, mail forms that the patient or a family member can complete at home. Try to structure questionnaires for easy reading by using large type and providing enough space between items for people to respond. Questionnaires to fill out in the waiting room should be brief.
- Try to have the patient tell his or her story only once, not to another staff member and then again to you. For older patients who are ill, this process can be very tiring.
- Sit and face the patient at eye level. Use active listening skills, responding with brief comments such as “*I see*” and “*okay*.”
- Be willing to depart from the usual interview structure. You might understand the patient’s condition more quickly if you elicit his or her past medical history immediately after the chief complaint, before making a complete evaluation of the present illness.
- If the patient has trouble with open-ended questions, make greater use of yes-or-no or simple choice questions.
- Remember that the interview itself can be beneficial. Although you see many patients every day, you may be the only person your patient is socially engaged with that day. Your attention is important. Giving your patient a chance to express concerns to an interested person can be therapeutic.

Elicit Current Concerns

Older patients tend to have multiple chronic conditions. They may have vague complaints or atypical presentations. Thinking in terms of current concerns rather than a chief complaint may be helpful. You might start the session by asking your patient to talk about his or her major concern, *“Tell me, what is bothering you the most?”*

Resist the Tendency to Interrupt

Give the patient time to answer your questions. Giving someone uninterrupted time to express concerns enables him or her to be more open and complete.

Probe

Ask, *“Is there anything else?”* This question, which you may have to repeat several times, helps to get all of the patient’s concerns on the table at the beginning of the visit.

The main concern may not be the first one mentioned, especially if it is a sensitive subject. If there are too many concerns to address in one visit, you can plan with the patient to address some now and some next time.

Encourage the patient and his or her caregivers to bring a written list of concerns and questions. Sometimes an older patient will seek medical care because of concerns of family members or caregivers.

Ask About Medications

Side effects, interactions, and misuse of medications can lead to major complications in older people. It is crucial to find out which prescription and over-the-counter medications older patients are using and how often. Older people often take many medications prescribed by several different doctors, e.g., internists, cardiologists, urologists, or rheumatologists. Sometimes they take prescriptions intended for other household members.

Remember to ask about any alternative treatments, such as dietary supplements, homeopathic remedies, or teas that the patient might be using. Remind patients that it is important for you to know what over-the-counter medicines, such as pain relievers or eye drops, they use.

Ask patients to bring all medications, both prescription and over-the-counter, to your office. A good approach is to have the patient put everything he or she takes in a brown bag and bring it to each visit. Find out about the patient's habits for taking each medication, and check to be sure that he or she is using it as directed.

Check to see if the patient has (or needs) a medical alert ID bracelet or necklace. There are several sources, including MedicAlert Foundation International, www.medicalert.org.

Obtain a Thorough Family History

The family history is valuable, in part because it gives you an opportunity to explore the patient's experiences, perceptions, and attitudes regarding illness and death. For example, a patient may say, "I never want to be in a nursing home like my mother." Be alert for openings to discuss issues such as advance directives.

The family history not only indicates the patient's likelihood of developing some diseases but also provides information on the health of relatives who care for the patient or who might do so in the future.

Knowing the family structure will help you to know what support may be available from family members, if needed.

Ask About Functional Status

Knowing an older patient's usual level of functioning and learning about any recent significant changes are fundamental to providing appropriate health care. They also influence which treatment regimens are suitable. The ability to perform basic activities of daily living (ADLs) reflects and affects a patient's health. Depending on the patient's status, ask about ADLs such as eating,

bathing, and dressing and more complex instrumental activities of daily living (IADLs) such as cooking, shopping, and managing finances. There are standardized ADL assessments that can be done quickly and in the office.

Sudden changes in ADLs or IADLs are valuable diagnostic clues. If your older patient stops eating, becomes confused or incontinent, or stops getting out of bed, look for underlying medical problems. Keep in mind the possibility that the problem may be acute.

Consider a Life History

If you plan to continue caring for an older patient, consider taking time to learn about his or her life. A life history is an excellent investment. It helps to understand the patient. It also strengthens the clinician-patient relationship by showing your interest in the patient as a person.

Be alert for information about the patient's relationships with others, thoughts about family members or coworkers, typical responses to stress, and attitudes toward aging, illness, work, and death. This information may help you interpret the patient's concerns and make appropriate recommendations.

Obtain a Social History

The social history also is crucial. If you are aware of your patient's living arrangements or his/her access to transportation, you are much more likely to devise realistic, appropriate interventions. Ask about where he or she lives; neighborhood safety; eating habits; tobacco, drug, and alcohol use; typical daily activities; and work, education, and financial situations. It also helps to find out who lives with or near the patient.

Understanding a person's life and daily routine can help you to understand how your patient's lifestyle might affect his or her health care. To this end, determine if the patient is an informal caregiver for others. Many older people care for spouses, elderly parents, or grandchildren. A patient's willingness to report symptoms sometimes depends on whether the patient thinks he or she can "afford to get sick," in view of family responsibilities.

House calls by a health care professional are an excellent way to find out about a patient's home life. If that's not possible, try to learn some details about the patient's home life: *"Do you use oil or gas heat? Have steep stairs to navigate? Own a pet? Can you get to the grocery store or pharmacy on your own? Are you friendly with anyone in the neighborhood?"* Learning about your patient's home life will help you understand aspects of his or her illness and may improve adherence to treatment.

In Summary

- ✓ Obtain basic information before the visit. Encourage patients to bring in written lists of concerns as well as all medication, including over-the-counter and alternative or homeopathic remedies.
- ✓ Use the family history to gain insight into an older patient's social situation as well as his or her risk of disease.
- ✓ Talk about the activities of daily living and be alert to changes.
- ✓ Ask about living arrangements, transportation, and lifestyle to help in devising appropriate interventions.

Encouraging Wellness

People of all ages can benefit from healthy habits such as regular exercise and good nutrition.

“I’d like you to try this exercise routine. Just start low and go slow.”

Mrs. Green is surprised when Dr. Lipton recommends that she exercise regularly. She responds with a list of excuses: exercise is for young people, it’s not safe for people over 65, it takes too much time, exercise equipment costs too much. Dr. Lipton listens empathetically and then tells her that exercise and physical activity are good for people of all ages and that being sedentary is far more dangerous than exercising. He explains that Mrs. Green can “start low and go slow” by walking for 10 minutes at a time and building up to at least 30 minutes of physical activity on 5 days or more each week. At her next office visit, Mrs. Green says that she has more energy than she used to; in fact, she’s ready to try a dance class at her senior center.

Exercise and Physical Activity

Exercise has proven benefits for older people. It reduces risk of cardiovascular disease, stroke, hypertension, type 2 diabetes, osteoporosis, obesity, colon cancer, and breast cancer. It also decreases the risk of falls and fall-related injuries.

Like the rest of us, older people may know that exercise is good for their health, but they may not have the motivation or encouragement to do it. You can guide your patients by asking about their daily activities and whether they engage in any kind of regular exercise or physical activity.

There are several ways to encourage older patients to exercise:

- Whenever appropriate, let them know that regular physical activity—including endurance, muscle-strengthening, balance, and flexibility exercises—is essential for healthy aging.
- Help patients set realistic goals and develop an exercise plan.
- Write an exercise prescription, and make it specific, including type, frequency, intensity, and time; follow up to check progress and re-evaluate goals over time.
- Refer patients to community resources, such as mall-walking groups and senior center fitness classes.
- Tell them about *Exercise and Physical Activity: Your Everyday Guide from the National Institute on Aging*, NIA's free book showing older adults how to start and stick with a safe, effective exercise program.

Too Old to Exercise? Studies Say 'No!'

- Together, exercise and lifestyle changes such as becoming more active and healthy eating reduce the risk of diabetes in high-risk older people. In one study, lifestyle changes led to a 71 percent decrease in diabetes among people 60 and older.
- In another study, moderate exercise was effective at reducing stress and sleep problems in older women caring for a family member with dementia.
- Older people who exercise moderately are able to fall asleep quickly, sleep for longer periods, and get better quality of sleep.
- Researchers also found that exercise, which can improve balance, reduced falls among older people by 33 percent.
- Walking and strength-building exercises by people with knee osteoarthritis help reduce pain and maintain function and quality of life.

Nutrition

Older patients may develop poor eating habits for many reasons. These can range from a decreased sense of smell and taste to teeth problems or depression. Older people may also have difficulty getting to a supermarket or standing long enough to cook a meal. And although energy needs may decrease with age, the need for certain vitamins and minerals, including calcium, vitamin D, and vitamins B₆ and B₁₂, increases after age 50.

Try these strategies to encourage healthy diets:

- Emphasize that good nutrition can have an impact on well-being and independence.
- If needed, suggest liquid nutrition supplements, but emphasize the benefits of solid foods.
- If needed, suggest multivitamins that fulfill 100 percent of the recommended daily amounts of vitamins and minerals for older people, but not megadoses.
- Offer a referral to a nutrition services program, such as Meals on Wheels. Programs in your area are provided by the local Area Agency on Aging or Tribal Senior Services. Contact Eldercare Locator at 800-677-1116 for your Area Agency on Aging.

In Summary

- ✓ Talk to your older patients about the importance of exercise and physical activity. Staying active can benefit older people in many ways.
- ✓ Encourage your patients to get a free copy of *Exercise and Physical Activity: Your Everyday Guide from the National Institute on Aging*.
- ✓ Talk to your older patients about their eating habits.
- ✓ Consider having your older patients keep a food diary, if necessary, to make sure they are getting the correct nutrients.

Talking About Sensitive Subjects

Caring for an older patient requires discussing sensitive topics. You may be tempted to avoid these discussions, but there are helpful techniques to get you started and resources to help.

“Many people your age experience similar problems.”

At age 80, Mr. Abayo was proud of his independence and ability to get around. But, when he came to see Dr. Carli for a regular exam, he acknowledged that the trouble with his shoulder had started after he collided with another car at a four-way stop sign.

“Many of my patients are worried about being safe drivers,”

Dr. Carli said. After the exam, she spoke with Mr. Abayo and his son in her office. She told them that a lot of her older patients had decided to rely on family and friends for transportation.

She gave Mr. Abayo a pamphlet on older drivers and the number of a local transportation resource that might be helpful.

Many older people have a “don’t ask, don’t tell” relationship with health care providers about some problems, especially those related to sensitive subjects, such as driving, urinary incontinence, or sexuality. Hidden health issues, such as memory loss or depression, are a challenge. Addressing problems related to safety and independence, such as giving up one’s driver’s license or moving to assisted living, also can be difficult.

You may feel awkward addressing some of these concerns because you don’t know how to help patients solve the problem. This chapter gives an overview

of techniques for broaching sensitive subjects, as well as resources for more information or support.

Try to take a universal, non-threatening approach. Start by saying, *“Many people your age experience . . .”* or *“Some people taking this medication have trouble with . . .”* Try: *“I have to ask you a lot of questions, some that might seem silly. Please don’t be offended . . .”* Another approach is to tell anecdotes about patients in similar circumstances as a way to ease your patient into the discussion, of course always maintaining patient confidentiality to reassure the patient you are talking to that you won’t disclose personal information about him or her.

Some patients avoid issues that they think are inappropriate for their own clinicians. One way to overcome this is to keep informative brochures and materials readily available in the waiting room. Along with each topic listed alphabetically below is a sampling of resources. Although the lists are not exhaustive, they are a starting point for locating useful information and referrals.

Advance Directives

Advance directives, including “living wills,” can help you honor individual end-of-life preferences and desires. You may feel uncomfortable raising the issue, fearing that patients will assume the end is near. But, in fact, this is a conversation that is best begun well before end-of-life care is appropriate. Let your patients know that advance care planning is a part of good health care. You can say that, increasingly, people realize the importance of making plans while they are still healthy. You can let them know that these plans can be revised and updated over time or as their health changes.

An advance care planning discussion can take about 5 minutes with a healthy patient:

- Talk about the steps your patient would want you to take in the event of certain conditions or eventualities.
- Discuss the meaning of a health care proxy and how to select one.
- Give the patient the materials to review, complete, and return at the next visit. In some cases, the patient may want help completing the form.

- Ask the patient to bring a copy of the completed form at the next visit for you to keep. If appropriate, share the plan with family members.
- Revise any advance directives based on the patient's changing health and preferences.

Be sure to put a copy of the completed form in the medical record. Too often, forms are completed, but when needed, they cannot be found. Many organizations now photocopy the forms on neon-colored paper, which is easy to spot in the medical record.

If your patient is in the early stages of an illness, it's important for you to assess whether or not the underlying process is reversible. It's also a good time to discuss how the illness is likely to play out. If your patient is in the early stages of a cognitive problem, it is especially important to discuss advance directives.

Driving Safety

Recommending that a patient limit driving—or that a patient give up his or her driver's license—is one of the most difficult topics a doctor has to address. Because driving is associated with independence and identity, making the decision not to drive is very hard.

As with other difficult subjects, try to frame it as a common concern of older patients. Mention, for instance, that aging can lead to slowed reaction times and impaired vision. In addition, it may be harder to move the head to look back, quickly turn the steering wheel, or safely hit the brakes. Ask the patient about any car accidents. When necessary, warn patients about medications that may make them sleepy or impair judgment. Also, a device such as an automatic defibrillator or pacemaker might cause irregular heartbeats or dizziness that can make driving dangerous. You might ask if she or he has thought about alternative transportation methods if driving is no longer an option.

Elder Abuse and Neglect

Be alert to the signs and symptoms of elder abuse. If you notice that a patient delays seeking treatment or offers improbable explanations for injuries, for example, you may want to bring up your concerns. The laws in most States require helping professionals, such as doctors and nurses, to report suspected abuse or neglect.

Older people caught in an abusive situation are not likely to say what is happening to them for fear of reprisal or because of diminished cognitive abilities. If you suspect abuse, ask about it in a constructive, compassionate tone. If the patient lives with a family caregiver, you might start by saying that caregiver responsibilities can cause a lot of stress. Stress sometimes may cause caregivers to lose their temper. You can assist by recommending a support group or alternative arrangements (such as respite care). Give the patient opportunities to bring up this concern, but if necessary, raise the issue yourself.

End-of-Life Care

Most older people have thought about the prospect of their own death and are willing to discuss their wishes regarding end-of-life care. You can help ease some of the discomfort simply by being willing to talk about dying and by being open to discussions about these important issues and concerns. It may be helpful to do this early in your relationship with the patient when discussing medical and family history. Stay alert to cues that the patient may want to talk about this subject again. Encourage the patient to discuss end-of-life decisions early with family members and to consider a living will.

Of course, it is not always easy to determine who is close to death; even experienced clinicians find that prognostication can be difficult. Even if you have already talked with your patient about end-of-life concerns, it still can be hard to know the right time to re-introduce this issue. Some clinicians find it helpful to ask themselves, *“Would I be surprised if Mr. Flowers were to die this year?”* If the answer is “no,” then it makes sense to start working with the patient and family to address end-of-life concerns, pain and

FLEX
FlexTherapistCEUs.com

symptom management, home health, and hospice care. You can offer to help patients review their advance directives. Include these updates in your medical records to ensure that patients receive the care they want.

Financial Barriers

Rising health care costs make it difficult for some people to follow treatment regimens. Your patients may be too embarrassed to mention their financial concerns. Studies have shown that many clinicians also are reluctant to bring up costs. If possible, designate an administrative staff person with a good bedside manner to discuss money and payment questions. This person can also talk with your patient about changes in Medicare and the Part D prescription drug coverage plans.

The resources in this section may help when you talk with your patients about their financial concerns. In addition, your State Health Insurance Assistance Program (SHIP) may be helpful.



Long-Term Care

Long-term care includes informal caregiving, assisted living, home health services, adult day care, nursing homes, and community-based programs.

Early in your relationship with an older patient, you can begin to talk about the possibility that he or she may eventually require long-term care of some kind. By raising this topic, you are helping your patient think about what he or she might need in the future and how to plan for those needs. For instance, you might talk about what sort of assistance you think your patient will need, how soon in the future he or she will need the extra help, and where he or she might get this assistance.

For more information on long-term care, contact:

Nursing Home Compare

www.medicare.gov/nhcompare/home.asp

Medicare provides an online resource with detailed information about the past performance of every Medicare- and Medicaid-certified nursing home in the country.

Eldercare Locator

800-677-1116 (toll-free)

www.eldercare.gov

The Eldercare Locator offers referrals to and information on services for seniors.

Mental Health

Despite many public campaigns to educate people about mental health and illness, there is still a stigma attached to mental health problems. Some older adults may find mental health issues difficult to discuss.

Such conversations, however, can be lifesavers. Primary care doctors have a key opportunity to recognize when a patient is depressed and/or suicidal. In fact, 70 percent of older patients who commit suicide have seen a primary care physician within the previous month. This makes it especially important for you to be alert to the signs and symptoms of depression.

As with other subjects, try a general approach to bringing up mental health concerns. For example, *“A lot of us develop sleep problems as we get older,*

but this can be a sign of depression, which sometimes we can treat.” Because older adults may have atypical symptoms, it is important to listen closely to what your patient has to say about trouble sleeping, lack of energy, and general aches and pains. It is easy to dismiss these as “just aging” and leave depression undiagnosed and therefore untreated.

Sexuality

An understanding, accepting attitude can help promote a more comfortable discussion of sexuality. Try to be sensitive to verbal and other cues. Don't assume that an older patient is no longer sexually active, does not care about sex, or necessarily is heterosexual. In fact, research has found that a majority of older Americans are sexually active and view intimacy as an important part of life. Depending on indications earlier in the interview, you may decide to approach the subject directly (for example, *“Are you satisfied with your sex life?”*) or more obliquely with allusions to changes that sometimes occur in marriage. If appropriate, follow up on patient cues. You might note that patients sometimes have concerns about their sex life and then wait for a response. It is also effective to share anonymous anecdotes about a person in a similar situation or to raise the issue in the context of physical findings (for example, *“Some people taking this medication have trouble . . . Have you experienced anything like that?”*). Don't forget to talk with your patient about the importance of safe sex. For example, *“It's been a while since your husband died. If you are considering dating again, would you like to talk about how to have safe sex?”* Any person, regardless of age, who is not in a long-term relationship with a faithful partner and has unprotected sex, is at risk of sexually transmitted disease.

Spirituality

For some older people, spirituality takes on new meaning as they age or face serious illness. By asking patients about their religious and spiritual practices, you can learn something about their health care choices and preferences. How a patient views the afterlife can sometimes help in framing the conversation.

For example, some patients feel that their fate is in the hands of a higher power, and this may prevent them from making treatment decisions. For patients who report suffering and distress about illness or end-of-life, a referral to a hospital or nursing home chaplain may be helpful.

Clinicians have found that very direct and simple questions are the best way to broach this subject. You might start, for instance, by asking, “*What has helped you to deal with challenges in the past?*”

Substance Abuse

Alcohol and drug abuse are major public health problems, even for older adults. Sometimes people can become dependent on alcohol or other drugs as they confront the challenges of aging, even if they did not have a problem when younger. Because baby boomers have a higher rate of lifetime substance abuse than did their parents, the number of people in this age group needing treatment is likely to grow.

One approach you might try is to mention that some medical conditions can become more complicated as a result of alcohol and other drug use. Another point to make is that alcohol and other drugs can increase the side effects of medication, or even reduce the medicine’s effectiveness. From this starting point, you may find it easier to talk about alcohol or other drug use.

Urinary Incontinence

About 17 percent of men and 38 percent of women age 60 and older suffer from urinary incontinence. Several factors can contribute to incontinence.

Childbirth, infection, certain medications, and some illnesses are examples. Incontinence may go untreated because patients are embarrassed to mention it. Be sure to ask specifically about the problem. Try the “some people” approach: *“When some people cough or sneeze, they leak urine. Have you had this problem?”* You may want to explain that incontinence can often be significantly improved through bladder training; medication and surgery can also be effective treatments for certain types of incontinence.

In Summary

- ✓ Introduce sensitive topics with the “common concern” approach: *“As we age, many of us have more trouble with . . .”* or *“Some people taking this medication have trouble with . . .”*
- ✓ Keep educational materials available and visible to encourage discussion.
- ✓ Raise topics such as safe driving, long-term care, advance care directives, and end-of-life care early, before they become urgent matters.

Supporting Patients With Chronic Conditions

Case managers can play an important role in educating patients and families and can connect them with appropriate community resources and services.

“Let’s discuss living with . . .”

Four years ago, Mrs. Smoley suffered a stroke. Although she takes her pills just like the doctor ordered, she has not been able to quit smoking. Now she has emphysema and may soon need oxygen. Dr. Nguyen thinks she should participate in a disease management program at a local hospital that will give her the information she needs to manage on her own. “It could help you prevent the problems you’ve had with shortness of breath,” the doctor explains. “And you might learn some tips about how to manage your day so that you have some more energy.” She offers to help Mrs. Smoley schedule her first appointment.

Approximately 80 percent of older adults have at least one chronic disease, and of those, 50 percent have at least two chronic conditions. For many older people, coping with multiple chronic conditions is a real challenge. Learning to manage a variety of treatments while maintaining quality of life can be problematic. People with chronic conditions may have different

needs, but they also share common challenges with other older adults, such as paying for care or navigating the complexities of the health care system.

Try to start by appreciating that people living with chronic disease are often living with loss—the loss of physical function, independence, or general well-being. Empathize with patients who feel angry, sad, lost, or bewildered. Ask, *“Is it hard for you to live with these problems?”* From there you can refer patients to community resources that may meet their needs or, when available, recommend a disease management program or case managers in the community.

Educating the Patient

Most older patients want to understand their medical conditions and are interested in learning how to manage them. Likewise, family members and other caregivers want this information. Physicians typically underestimate how much patients want to know and overestimate how long they spend giving information to patients. Devoting more attention to educating patients may seem like a luxury, but in the long run it can improve patients' adherence to treatment, increase patients' well-being, and save you time.

The following tips can help you inform patients and their caregivers about medical conditions and their treatment.

- Doctors' advice generally receives greatest credence, so the doctor should introduce treatment plans. Other medical team members have an important role, including building on the original instructions.
- Let your patient know you welcome questions. Indicate whom on your staff he or she can call to have questions answered later.
- Remember that some patients won't ask questions even if they want more information. Be aware of this tendency and think about making information available even if it is not requested.
- Provide information through more than one channel. In addition to talking to the patient, you can use fact sheets, drawings, models, videotapes, or audiotapes. In many cases, referrals to websites and support groups can be helpful.

- Encourage the patient or caregiver to take notes. It's helpful to offer a pad and pencil. Active involvement in recording information may promote your patient's retention and adherence.
- Repeat key points about the health problem and treatment at every office visit.
- Check that the patient and his or her caregivers understand what you say. One good approach is to ask that they repeat the main message in their own words.
- Provide encouragement. Call attention to strengths and ideas for improvement. Remember to provide continued reinforcement for new treatment or lifestyle changes.

Explaining Diagnoses

Clear explanations of diagnoses are critical. Uncertainty about a health problem can be upsetting. When patients do not understand their medical conditions, they tend not to follow the treatment plans.

In explaining diagnoses, it is helpful to begin by finding out what the patient believes is wrong, what the patient thinks will happen, and how much more he or she wants to know. Based on the patient's responses, you can correct any misconceptions and provide appropriate types of information.

Discussing Treatment

Some older patients may refuse treatment because they do not understand what it involves or how it will improve their health. In some cases, they may be frightened about side effects or have misinformation from friends and relatives with similar health problems. They may also be concerned about the cost of the treatment.

Treatment can involve lifestyle changes (such as diet and exercise) as well as medication. Make sure you develop and communicate treatment plans with the patient's input and consent. Tell the patient what to expect from the treatment, including recommended lifestyle change, what degree of improvement is realistic, and when he or she may start to feel better.

Keep medication plans as simple and straightforward as possible. For example, minimize the number of doses per day. Tailor the plan to the patient's situation and lifestyle, and try to reduce disruption to the patient's routine. Indicate the purpose of each medication. Make it clear which medications must be taken and on what schedule. It is helpful to say which drugs the patient should take only when having particular symptoms.

After proposing a treatment plan, check with the patient about its feasibility and acceptability. Work through what the patient feels may be obstacles to maintaining the plan. Try to resolve any misunderstandings. For example, make it clear that a referral to another doctor does not mean you are abandoning the patient. Provide oral and written instructions. Do not assume that all of your patients are able to read. Make sure the print is large enough for the patient to read.

Encourage your patient and his or her caregivers to take an active role in discovering how to manage chronic problems. Think in terms of joint problem solving or collaborative care. Such an approach can increase the patient's satisfaction while decreasing demands on your time.

In Summary

- ✓ The physician should provide key information and advice for greatest impact; other team members can build on that.
- ✓ To explain diagnoses, start by asking the patient what he or she understands and how much more he or she wants to know.
- ✓ After proposing a treatment plan, check with the patient on feasibility and acceptability; confirm that the patient understands the plan.
- ✓ Encourage the patient and caregivers to take an active role in managing a chronic problem.

Breaking Bad News

Delivering bad news is never easy, but tested strategies can ease the process.

“I wish I had better news.”

Since Dr. Callas got Mrs. Larson’s test results, he had been thinking about how to tell her she has Parkinson’s disease. Because he didn’t want to feel pressured for time, Dr. Callas made sure Mrs. Larson had today’s last appointment. He knew she’d have a lot of questions. Knowing that Mrs. Larson suspected something was seriously wrong, Dr. Callas decided the best approach was to be gentle, but direct. He reviewed her chart for details, took a deep breath, and opened the exam room door . . .

Knowing how to communicate bad news can help you to make the process more bearable for patients. The Education in Palliative and End-of-Life Care Project (EPEC), www.epec.net, offers a module, “Communicating Bad News,” that provides a practical approach. It indicates that breaking bad news in a compassionate yet direct way can help physicians and patients. And, although some of the advice may seem obvious, it may also be the sort of thing that is easily overlooked.

The first step is to prepare yourself. Before meeting with the patient, think about what you want to say and make sure that you have all of the information you need. Be sure there is enough time, rather than trying to schedule it between other appointments. If possible, ask your staff to hold calls and pages until the appointment is over.

You may feel more comfortable by first finding out what the patient knows about his or her condition. You might ask questions such as, “*Have you been worried about your illness or symptoms?*”

Next, you might spend a few moments finding out how much the patient really wants to know. Depending on their cultural background, personal history, or medical status, people may have different expectations and preferences for what they should be told. You might ask the patient if he or she wants to hear the prognosis, for example, or would prefer not to know.

If a patient’s family has reservations about having the patient know the prognosis, you might ask them about their concerns. Legally, of course, you are obligated to tell the patient; however, you may negotiate some elements with the family. If you cannot resolve it, an ethics consultation may be helpful.

When you are ready to share the bad news, try to be as straightforward as possible, without speaking in a monotone or delivering a monologue. Be positive, but avoid the natural temptation to minimize the seriousness of the diagnosis. Communications experts suggest that you not start by saying, “*I’m sorry . . .*” Instead, try saying, “*I feel bad to have to tell you . . .*” After you have explained the bad news, you can express genuine sadness while reassuring the patient that you and others will be there to help.

Of course, people will respond differently to bad news; shock, anger, sorrow, despair, denial, blame, disbelief, and guilt all are common reactions. In some cases, people may simply have to leave the office. Try to give the patient and family time—and privacy—to react.

A good way to end this visit is to establish a plan for next steps. This may include gathering more information, ordering more tests, or preparing advance directives. Reassure the patient and family that you are not going to abandon them, regardless of referrals to other health care providers. Let them know how they can reach you—and be sure to respond when they call.

In follow-up appointments or conversations, give the patient an opportunity to talk again about the situation. Ask if he or she has more questions or needs help talking with family members or others about the diagnosis. Assess the patient’s level of emotional distress and consider a referral to a mental health provider.

The Language of Bad News: Phrases That Help

These phrases can help you to be straightforward, yet compassionate:

Delivering bad news

- “I’m afraid the news is not good. The biopsy showed you have colon cancer.”
- “Unfortunately, there is no question about the results. You have emphysema.”
- “The report is back, and it’s not as we had hoped. It confirms that you have the early stages of Parkinson’s disease.”

Responding to patient reactions

- “I imagine this is difficult news.”
- “Does this news frighten you?”
- “I wish the news were different.”
- “Is there anyone you’d like me to call?”
- “I’ll try to help you.”
- “I’ll help you tell your children.”

Dealing with prognosis

- “What are you expecting to happen?”
- “What would you like to have happen?”
- “How specific would you like me to be?”
- “What are your fears about what might happen?”

Referring Patients to Clinical Trials

Carefully conducted clinical trials are the primary way researchers find out if a promising treatment is safe and effective. Patients who participate in clinical research can gain access to new treatments before they are widely available and help others by contributing to medical research findings. Clinicians have an important role in continuing to care for patients who participate in clinical trials. Most trials offer short-term treatments related to a specific illness or condition. They do not provide extended or complete primary health care. You will continue your involvement in the patient's care but may need to communicate at times with your patient's clinical research team. By working with the research team, you can ensure that other medications or treatment needed by your patient will not conflict with the protocol.

For information about federally and privately supported clinical research, visit:
www.clinicaltrials.gov

In Summary

- ✓ Prepare yourself for delivering bad news—allow enough time, and have calls held.
- ✓ Find out how much the patient understands and how much he or she wants to know about the prognosis.
- ✓ Be straightforward and compassionate.
- ✓ Give the patient time to react.
- ✓ Establish a plan for next steps; let the patient and family know you are not going to abandon them.
- ✓ Give the patient an opportunity to continue the conversation in follow-up appointments or calls.

Working With Diverse Older Patients

Appreciating the richness of cultural and ethnic backgrounds among older patients and providing interpretation for those with limited English can help to promote good health care.

“Cultural differences, not divides.”

Azeeza Houssani had been Dr. Smith’s patient for several years. She had always carefully followed his instructions. So, Dr. Smith was surprised when Mrs. Houssani was not willing to take her morning medication with food, as directed. He reminded her that these drugs were very hard on the stomach and could cause her pain if taken without food. But Mrs. Houssani just shook her head. Rather than getting frustrated, Dr. Smith gently pursued her reasons. Mrs. Houssani explained that it was Ramadan and she could not eat or drink from sunrise to sunset. Dr. Smith thought a bit and suggested that she find out if it’s okay to take medicine with food during Ramadan—there might be an exception for people in her situation who need to take medicine.

Understanding how different cultures view health care helps you to tailor questions and treatment plans to the patient’s needs. Although you cannot become an expert in the norms and traditions of every culture, being sensitive to general differences can strengthen your relationship with your patients.

Each culture has its own rules about body language and interpretations of hand gestures. Some cultures point with the entire hand, because pointing with a finger is extremely rude behavior. For some cultures, direct eye contact is considered disrespectful. Until you are sure about a patient's background, you might opt for a conservative approach. And, if you aren't certain about a patient's preferences, ask.

The use of alternative medicines, herbal treatments, and folk remedies is common in many cultures. Be sure to ask your patient if he or she takes vitamins, herbal treatments, dietary supplements, or other alternative or complementary medicines. Also, in order to help build a trusting relationship, be respectful of native healers on whom your patient may also rely.

Older immigrants or non-native English speakers may need a medical interpreter. Almost 18 percent of the U.S. population speaks a language other than English at home, according to the Census Bureau. Among older people, 2.3 million report not speaking English or not speaking it very well. Federal policies require clinicians and health care providers who receive Federal funds, such as Medicare payments, to make interpretive services available to people with limited English.

Many clinicians rely on patients' family members or on the ad hoc services of bilingual staff members, but experts strongly discourage this practice and recommend the use of trained medical interpreters. Family members or office staff may be unable to interpret medical terminology, may inadvertently misinterpret information, or may find it difficult to relay bad news. Although a patient may choose to have a family member translate, the patient should be offered access to a professional interpreter.

When working with non-native English-speaking patients, be sure to ask which language they prefer to speak and whether or not they read and write English (and, if not, which language they do read). Whenever possible, offer patients appropriate translations of written material or refer them to bilingual resources. If translations are not available, ask the medical interpreter to translate medical documents.

Finding a Medical Interpreter

A number of States have associations and foundations that can help with locating, and in some cases provide funding for, medical interpreters. Some State Medicaid offices offer reimbursement for medical interpretation services. A web search can locate State organizations and local services. Or you can contact:

National Council on Interpreting in Health Care

5505 Connecticut Avenue, NW, #119

Washington, DC 20015-2601

518-459-3443 (fax)

www.ncihc.org

In Summary

- ✓ Keep in mind that cultural differences have an impact on how patients view doctors and medicine.
- ✓ Ask about patients' use of alternative and complementary medicines.
- ✓ Use a professional medical interpreter rather than family members or untrained staff.
- ✓ Provide written materials in the patient's primary language.

Including Families and Caregivers

By communicating effectively with all the individuals involved in your patient's care, you can help him or her while also making efficient use of time and resources.

“What would you like your family to know?”

Dr. Hwang noticed that Mrs. Patrick wasn't getting her medication dosage quite right. Mrs. Patrick admitted that sometimes she does not remember everything prescribed for her to do. Dr. Hwang wondered if Mrs. Patrick should bring her daughter to her next appointment. Mrs. Patrick agreed, but at the following doctor visit she still came alone. Dr. Hwang was puzzled. When he asked her about it, Mrs. Patrick said that she was concerned her daughter wouldn't let her speak for herself and that she has some personal issues she'd like to discuss with him that she doesn't want her daughter to know about. Dr. Hwang assured her that he would keep her involved in the conversation about her health and that they could have some private time to discuss any personal matters. Next time, Mrs. Patrick brought her daughter to the visit.

Family and informal caregivers play an important role in the lives of their loved ones. They also play an increasingly important role in how the health care system functions.

Informal caregivers may be important “informants.” They can also help to reinforce the importance of information you give or the treatment you prescribe.

To protect and honor patient privacy, be sure to check with the patient on how he or she sees the companion’s role. In many cases, the caregiver or companion can be a facilitator, helping the patient express concerns and reinforcing what you say. But it is best not to assume that a companion should be included in the medical encounter. First, check with the patient. Conducting the physical exam alone protects the patient’s privacy and allows you to raise sensitive issues. For instance, the best time to conduct a “mini-mental” test is during a private exam, so that a family member cannot answer questions or cover for the patient’s cognitive lapses.

When a companion is present, be aware of communication issues that arise in three-party interactions. Whenever possible, try to sit so that you form a



triangle and can address both the patient and companion face-to-face. Be careful not to direct your remarks to the companion. By not falling into this trap, you can prevent the encounter from feeling like a “two against one” match.

Families may want to make decisions for a loved one. Adult children especially may want to step in for a parent who has cognitive impairments. If a family member has been named the health care agent or proxy, under some circumstances, he or she has the legal authority to make care decisions. However, without this authority, the patient is responsible for making his or her own choices. Try to set clear boundaries with family members, and encourage others to respect them.

Family caregivers face many emotional, financial, and physical challenges. They often provide help with household chores, transportation, and personal care. More than one-third also give medications, injections, and medical treatments to the person for whom they care. It makes sense to view informal caregivers as “hidden patients” and be alert for signs of illness and stress. Caregivers may find it hard to make time for themselves. Encourage them to seek respite care so that they can recharge and take a break from the loved one. And remember, your encouragement and praise can help to sustain a caregiver.

In Summary

- ✓ Check with the patient on how he or she would like any family members or companions to participate in the medical encounter.
- ✓ Address the patient—try to avoid talking only to the family member or companion.
- ✓ Make it clear that the patient should make his or her own decisions unless legal authority to do so has been granted to someone else.
- ✓ Be alert to family caregivers’ own health needs, including signs of stress.

Talking With Patients About Cognitive Problems

Communicating with a confused patient holds special challenges. Specific techniques can help health care providers to talk with patients and caregivers about a diagnosis.

“You mentioned having trouble with your memory.”

Jonathan Jones had always been a meticulously organized man. His bills were paid on time; his car gas tank was always at least half full. He could be counted on to arrive slightly early for every appointment. Dr. Ross knew all this because he'd been taking care of the Jones family for nearly 30 years. So when Mr. Jones missed two appointments in a row, Dr. Ross knew something was not right and called him at home. The phone rang for quite a while before Mr. Jones answered, “Yes? Hello, Dr. Ross. Why are you calling? I don't have an appointment scheduled with you.” The conversation added to Dr. Ross's concerns. The doctor made a note on the chart—it was time to broach the subject of memory loss with Mr. Jones. After so many years, this was going to be a hard discussion.

Cognitive Impairment

Aging itself can cause deficits in cognition that vary from person to person. While some older people show little or no decrease in cognitive function, others may be very worried about their memory and may fear dementing disorders such as Alzheimer's disease (AD). But, not all cognitive problems are caused by AD. Various illnesses, both physical and mental, can cause temporary, reversible cognitive impairment. Certain drug combinations can also cause a problem.

Identifying and working with older adults who have cognitive impairment are important for their safety and for the safety of others. Older patients with cognitive impairment can develop difficulties in remembering and correctly adhering to instructions about medications for their other health problems. In addition, activities such as cooking and driving can become dangerous.

Many patients with cognitive impairments experience behavioral changes. For instance, they may withdraw from or lose interest in activities, grow irritable or uncharacteristically angry when frustrated or tired, or become insensitive to other people's feelings. During more advanced stages of cognitive impairment, people may behave inappropriately—kicking, hitting, screaming, or cursing. Depending on the stage of the disease, you can suggest activities that your patient might still enjoy—for example, listening to music and perhaps dancing, playing games, gardening, or spending time with pets.

Some of your older patients may have a specific condition called mild cognitive impairment (MCI). People with MCI have ongoing memory problems but do not have other losses associated with AD such as confusion, attention problems, or difficulty with language. Some people's cognitive problems may not get worse for many years. Some people with MCI may convert to AD over time. Research is ongoing to determine better which people with MCI will develop AD.

The suggestions in this section of the booklet pertain specifically to effective communication with patients with cognitive impairments.

Diagnosis

Accurate diagnosis of AD or other cognitive problems can help your older patient and his or her family to plan for the future. Early diagnosis offers the best chance to treat the symptoms of the disease, when possible, and to

discuss ways of positively coping with the condition, including discussing care options. A relatively early diagnosis allows patients to make financial plans, prepare advance directives, and express informed consent for research. Yet data suggest that only a small fraction of people with AD are ever diagnosed.

When patients are only mildly impaired, they can be adept at covering up what is happening to them. However, giving a few straightforward tests, using a medical history, and taking a family history from another family member can often tell you if there are persistent or worsening problems. It is best to conduct tests or interviews with the patient alone so that family members or companions cannot prompt the patient. Information can also be gleaned from the patient's behavior on arrival in your office or from telephone interactions with staff. Family members who may contact you in advance or following the visit are also a source of information, but keep in mind patient privacy concerns.

Although assessing an older person's cognitive function is important, formal testing of mental status tends to provoke anxiety. If you are concerned about a patient's cognition, it might be best to leave any formal testing of mental status until the latter part of the appointment—either between the history and the physical examination or after the examination—or to refer the patient to a neuropsychologist for more detailed assessment of cognition. If you administer a cognitive status test, try to present it in the context of concerns the patient has expressed. Providing support and encouragement during the testing can decrease stress.

There are limitations to any mental status test—for example, the test results can reflect level of education, or the results may appear normal early in the disease. The most commonly used screen is the Mini-Mental State Examination. This test can be used to screen patients for cognitive impairment and can be administered in the primary care setting in about 10 minutes. A positive finding suggests the need for referral to a neurologist or neuropsychologist for a more detailed diagnosis.

Cognitive impairment may reflect a variety of conditions, some reversible. In particular, it is important to review your patient's medications to check for anticholinergic or other potentially inappropriate medications. However,

since patients or caregivers may assume that the cause is Alzheimer's disease, you may need to explain the need for a careful history, laboratory tests, and physical examination to search for other conditions or issues.

If your patient does have mild to moderate cognitive impairment, you might ask if there is someone who helps when he or she has trouble remembering. If your patient says yes, you could also ask if it would be a good idea for you to discuss the patient's treatment plans with the helper and keep his or her name in your notes for future reference. Make these arrangements early, and check that the patient has given you formal authorization to include the helper in the conversation about your patient's care.



Communicating With a Confused Patient

- Try to address the patient directly, even if his or her cognitive capacity is diminished.
- Gain the person's attention. Sit in front of him or her and maintain eye contact.
- Speak distinctly and at a natural rate of speed. Resist the temptation to speak loudly.
- Help orient the patient. Explain (or re-explain) who you are and what you will be doing.
- If possible, meet in surroundings familiar to the patient. Consider having a family member or other familiar person present at first.
- Support and reassure the patient. Acknowledge when responses are correct.
- If the patient gropes for a word, gently provide assistance.
- Make it clear that the encounter is not a "test," but rather a search for information to help the patient.
- Use simple, direct wording. Present one question, instruction, or statement at a time.
- If the patient hears you but does not understand you, rephrase your statement.
- Although open-ended questions are advisable in most interview situations, patients with cognitive impairments often have difficulty coping with them. Consider using a yes-or-no or multiple-choice format.
- Remember that many older people have hearing or vision problems, which can add to their confusion.
- Consider having someone call the patient to follow up on instructions after outpatient visits.
- If the patient can read, provide written instructions and other background information about the problem and options for solutions.

Conveying Findings

Some patients may prefer a cautious, reserved explanation. You might consider saying something like, *“You have a memory disorder, and I believe it will get worse as time goes on. It’s not your fault. It may not help for you to try harder. Now is probably a good time for you to start making financial and legal plans before your memory and thinking get worse.”* Some patients may prefer more precise language and appreciate it when a doctor uses specific words like Alzheimer’s disease. If possible, schedule additional time for the appointment so that you can listen and respond to the patient’s or caregiver’s concerns. Also, if possible, offer to have a follow-up appointment to further discuss what to expect from the diagnosis.

Regardless of how you present the diagnosis, providing written materials can make a big difference in helping your patient and his or her family know what to expect. The NIA’s Alzheimer’s Disease Education and Referral (ADEAR) Center has free publications you can include in a patient/caregiver information packet. You might want to refer your patient to a neurologist or neuropsychologist for testing. The Alzheimer’s Association or other supportive organizations can provide assistance in planning, social services, and care.

Informing family members or others that the patient may have Alzheimer’s disease or any cognitive impairment may be done in a family conference or group meeting, which should be arranged with the consent of the patient. In some situations, a series of short visits may be more suitable. You should make clear you will continue to be available for care, information, guidance, and support. If you are unable to provide all of these services, it would make a tremendous difference if you could refer the patient and family to a service organization.

Working With Family Caregivers

All family caregivers face challenges, but these challenges are compounded for people caring for patients with Alzheimer’s disease and other dementias. The patient usually declines slowly, over the course of several years. This is an

exhausting and disturbing experience for everyone. The following suggestions are especially useful for family caregivers in these situations:

- Persuade caregivers to get regular respite, especially when patients require constant attention. Ask if the caregiver, who is at considerable risk for stress-related disorders, is receiving adequate health care.
- Explain that much can be done to improve the patient's quality of life. Measures, such as modifications in daily routine and medications for anxiety, depression, or sleep, may help control symptoms.
- Let the caregivers know there is time to adapt. Decline is rarely rapid. Provide information about the consumer resources and support services available from groups.
- Help caregivers plan for the possibility that they eventually may need more help at home or may have to look into residential care.

In Summary

- ✓ Using a simple screen, such as the Mini-Mental State Examination, assess the patient's cognitive function when alone with him or her. Refer the patient to a specialist (e.g., neurologist or neuropsychologist) for diagnosis of cognitive impairment.
- ✓ Reassure the patient if there is no serious mental decline.
- ✓ Decide how to talk about serious cognitive problems, depending on how much the patient wants to know and can understand.
- ✓ Communicate with family members in a family conference, arranged with the patient's consent.
- ✓ Suggest activities that the patient and family might still enjoy.
- ✓ Be alert to caregivers' needs for information, resources, and respite.

Keeping the Door Open

“Effective Communication”

Advising an older man about starting an exercise program . . . counseling a woman about the proper way to take her osteoporosis medication . . . discussing end-of-life care options with the family of a long-time older patient who is dying. These are just some examples of the complex and sensitive issues facing clinicians who treat older people. Health care providers who communicate successfully with older patients may gain their trust and cooperation, enabling everyone to work as a team to handle physical and mental health problems that might arise. Effective communication techniques, like those discussed in this handbook, can save time, increase satisfaction for both patient and practitioner, and improve the provider’s skill in managing the care of his or her patients.

Ongoing communication is key to working effectively with your older patient. If a patient does not follow recommendations or starts missing appointments, explore whether or not a difficulty in communication has developed. Paying attention to communication increases the odds of greater health for your patient and satisfaction for you both.

Publications

AT-A-GLANCE

Fact sheets, called *AgePages*, are available on a variety of topics. The asterisk (*) indicates those also available in Spanish.

Diseases/Conditions

- Arthritis Advice*
 - Cancer Facts for People Over 50*
 - Diabetes in Older People*
 - Hearing Loss*
 - High Blood Pressure*
 - Osteoporosis*
 - Prostate Problems*
 - Shingles
 - Stroke*
-

Safety

- Crime and Older People*
 - Falls and Fractures*
 - Medicines: Use Them Safely*
 - Older Drivers*
 - Online Health Information: Can You Trust It?
-

Wellness

- A Good Night's Sleep*
- Aging and Your Eyes*
- Concerned About Constipation?*
- Dietary Supplements
- Exercise and Physical Activity: Getting Fit for Life*
- Flu—Get the Shot*
- Foot Care*
- Healthy Eating After 50
- Hyperthermia*

(continued on next page)

Wellness (*continued*)

- *Hypothermia**
 - *Shots for Safety**
 - *Skin Care and Aging*
 - *Smoking: It's Never too Late to Stop*
 - *Taking Care of Your Teeth and Mouth**
-

Sensitive Subjects

- *Alcohol Use and Abuse**
- *Beware of Health Scams**
- *Considering Surgery**
- *Depression: Don't Let the Blues Hang Around**
- *Forgetfulness: Knowing When to Ask for Help**
- *Getting Your Affairs in Order*
- *HIV, AIDS, and Older People**
- *Mourning the Death of a Spouse*
- *Nursing Homes: Making the Right Choice**
- *Sexuality in Later Life**
- *Urinary Incontinence**

More in-depth publications are also available.

- *End of Life: Helping With Comfort and Care*
- *Exercise and Physical Activity: Your Everyday Guide from the National Institute on Aging*
- *So Far Away: Twenty Questions for Long-Distance Caregivers*
- *Talking With Your Doctor: A Guide for Older People*
- *There's No Place Like Home—for Growing Old: Tips from the National Institute on Aging*

NIA's ADEAR Center has a wide variety of free publications for patients with cognitive problems, their families, and caregivers, such as *Understanding Alzheimer's Disease and Caregiver Guide: Tips for Caregivers of People with Alzheimer's Disease*.

To order, contact:

Alzheimer's Disease Education and Referral Center

P.O. Box 8250

Silver Spring, MD 20907-8250

800-438-4380 (toll-free)

www.nia.nih.gov/Alzheimers

Services AT-A-GLANCE

You want to help your patients get the services they need. But you may not be sure where to find the right resource. This is a starting place. We've identified some of the most common concerns and listed a few national resources that might be helpful.

What's the Problem?	What's a Solution?	Helpful Resources
Abuse/neglect	Mandatory reporting to adult protective services	National Center on Elder Abuse For your State Adult Protective Services: www.ncea.aoa.gov Call local police or 911, if serious situation
Caregiver assistance	Respite care	National Respite Locator Service 800-773-5433 (toll-free) www.respitelocator.org
Caregiving	Adult day care, nursing home care	National Adult Day Services Association 877-745-1440 (toll-free) www.nadsa.org Nursing Home Compare service www.medicare.gov/nhcompare/home.asp
Daily living assistance	Home health aide	Eldercare Locator 800-677-1116 (toll-free) www.eldercare.gov
Financial assistance	Case manager or supportive community programs	National Council on Aging To assess eligibility: www.benefitscheckup.org
Health information	Free fact sheets, booklets, and web resources	National Institute on Aging Information Center 800-222-2225 (toll-free) www.nia.nih.gov/HealthInformation NIH SeniorHealth www.nihseniorhealth.gov National Institutes of Health National Library of Medicine www.medlineplus.gov
Household assistance	Homemaker assistant	Eldercare Locator 800-677-1116 (toll-free) www.eldercare.gov
Nutrition	Meals on Wheels or congregate meal sites	Meals on Wheels Association of America 703-548-5558 www.mowaa.org
Social support	Volunteer companions	Eldercare Locator 800-677-1116 (toll-free) www.eldercare.gov
Transportation	Medical transport benefits or other community programs	National Association of Area Agencies on Aging 202-872-0888 www.n4a.org National Transit Hotline 800-527-8279 (toll-free)
Utility costs	Utility subsidies	National Energy Assistance Referral Project 866-674-6327 (toll-free) http://liheap.ncat.org/referral.htm



“This course was developed from the public domain document: A Clinician’s Handbook: Talking With Your Older Patients - National Institute on Aging, National Institute of Health and the Department of Health and Human Services.”