Women and Their Health Care Providers: A Matter of Communication

Communication Barriers Between Older Women and Physicians

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Synopsis

Communication barriers between health care providers and older women are multifaceted and complex. The acute care, hospital-based orientation of the health care system tends to bypass the characteristic problems of older women who need services. Breakdown in communication originates both with the provider and the recipient.

Some inherent changes of aging due to sensory loss may be a major factor. Decline in vision, hearing, and touch make communication difficult for both parties. Other deficits may occur due to disease processes such as diabetes and hypertension.

A frequently ignored problem is that of the language barrier between laywomen and physicians. Use of jargon and a nonempathic interviewing style by the doctor tend to discourage free exchange of information.

A third consideration is the many psychosocial factors which affect the behavior of older women and their relationship with providers. One element is the belief in negative stereotypes of women in general, and older women in particular. Fear of being labeled a "hypochondriac," a "nuisance," or a "crabby old woman" inhibits accurate reporting by patients. Attitudes toward doctors, especially male doctors, make some older women timid and fearful. Physician and patient alike may accept signs and symptoms of disease as a normal part of aging and may cause medically treatable problems to be overlooked. Finally, patient and physician priorities may differ widely. The belief by either party that wellness, prevention, and health promotion are not realistic goals for the older woman may push the individual patient into premature frailty and disability which could otherwise by postponed.

WHEN USING THE TERM "older woman," most people conventionally think of those 65 years of age and older, but it is important to stress the wide range of aging seen within the population (*1*). Not only do persons show individual variation in the normal changes of aging, but also each person varies in her own rate of aging in one organ system compared to another. For example, a specific woman may have cardiovascular disease and impaired hearing but her digestive and musculoskeletal systems may work as well as ever.

The topic of communication is so vast that it is necessary to draw a very broad circle around the problems involved in barriers that exist rather than addressing specific details. Effective communication is crucial to the adequate delivery of health care; likewise, communication breakdown is at the core of many of the failures.

If one looks at health problems common to the older population and relates them to the characteristics of the health care delivery system, a mismatch is readily apparent (*2*). Problems common to the older population include the following:

1. Patients who do not present themselves to the provider for care even though they may have a complaint. It can also include those who present themselves for care but do not mention, acknowledge, or even recognize a situation that may need attention.
2. A combination of psychological, social, and physical factors which interact to make medical care complex.
3. A tendency toward multiple, continuingly chronic problems rather than acute short-term problems.
4. The need for screening, early diagnosis, and

preventive care. These items are largely ignored by both the consumer and the provider due to widely prevalent negative attitudes toward aging in our society (*1*). This is unfortunate because the longer a person has a chronic condition that goes undiagnosed and untreated, the more likely that individual will suffer irreversible effects.

5. Atypical or vague presentation of symptoms due to the tendency of the older body to manifest disease processes less dramatically and definitively than it did in earlier decades.

6. Iatrogenic (physician-induced) disease. Well-meaning physicians may unintentionally create problems by their use of medications, treatments, and procedures.

7. Compliance (that is "following the doctor's orders"). Adherence to medical regimens may become more difficult and complicated for a variety of reasons.

8. Institutionalization. This issue includes not only entry into the nursing home but also hospitalization. Many trips to the hospital could be avoided if continuity of communication between patients and physicians was maintained and problems dealt with as they arise.

Characteristics of the health care system (perhaps more appropriately termed the medical care system) are geared toward a different set of problems than those characteristics of older people. The medical care system tends to be adapted to episodic rather than chronic care and focuses on hospital-based, medical specialty treatment. If a patient has a heart attack, her gall bladder needs to be removed, or she is involved in an automobile accident, she may be well-served by the present arrangement. Additionally, if she is able to prediagnose her condition well enough to guess which specialist she needs to see she may also fare well. However, if she is an older woman with a combination of arthritis, high blood pressure, obesity, and anemia, she may be perplexed by trying to decide which specialist to see under what circumstances, as well as how freqeuntly she needs treatment.

Some of the vexation in meeting health needs arises from the medical care system itself, but some arises from three categories of communication barriers: sensory losses, language problems, and psychosocial factors. Many aging persons undergo sensory loss as a part of the normal aging process and others experience disease conditions which cause them to lose valuable input from the senses of vision, hearing, and touch (*3*). Another impediment is language problems. Such problems refer not to a "foreign" language or neurological and psychological linguistic deficits but to medical jargon as compared to the patient's language. A third barrier is psychosocial and takes into account many complex behaviors from both the consumer and the provider.

Sensory Loss

Sensory decline occurs throughout adult life, but some changes which affect our ability to function may begin to accelerate between 40 and 50 years of age. Again, the wide variation in these kinds of changes as a result of normal aging must be emphasized. However, deficits in sensory abilities can generally be anticipated (*3*). For example, there will be the problem of low vision or presbyopia. "Presbys" is a Greek word meaning "old man" and "opia" is a suffix meaning "eyes or vision". Presbyopia narrowly defined refers to those changes which affect the eye's ability to accomodate to near vision. However, this disorder, as well as some other normal changes that may take place within the eye, cause the older person to have problems with blurring of objects, as well as inability to focus rapidly and adapt to low light. Additionally, the affected person may experience more glare from bright, high-intensity light. Some difficulty in discerning color intensities, especially blues, greens, and violets, may also begin at these ages. A loss in the ability to judge distances well may be a simultaneous defect in this perceptual system. The environment takes on a somewhat flattened appearance. These changes can be important to the patient's attempt to comply effectively with medical advice. The patient could experience difficulties such as an inability to read instructions on a pill bottle, discern the difference between blue, green, and pale pink pills, drive, use public transportation, and make selections while shopping in a supermarket that has bright fluorescent lights reflecting in a glass case.

Of course, there are other low vision problems brought about by medical conditions such as cataracts, glaucoma, and diabetic or hypertensive eye disease which may lead to a blurring and yellowing effect. Some of these situations are aided by eyeglasses; others are not. Frequently patients are dismayed when told they do not need glasses but still have poor vision. Often, an adequate explanation has not been communicated by the physician.

Even a patient who genuinely wants to comply with her doctor's orders may face uneven odds when she cannot read the instructions on a prescription bottle (even with her new glasses), cannot recall exactly what her doctor said to do, has been given no

written instructions, and is not absolutely sure for what disorder she is being treated.

The most socially isolating of all sensory losses is hearing impairment. Presbycusis (literally translated means "old hearing") reduces the ability to hear sounds in general and to hear high frequencies in particular. Many of the tones of normal conversation are in the high frequency range. Consonants and sounds such as s, sh, t, th, f, and h may be hard to distinguish, causing many words to sound the same. This condition clearly demonstrates the handicap imposed upon someone in a culture that is based very heavily on auditory stimuli. Having to turn the TV and radio up loud, asking people to repeat themselves, straining to hear normal conversational tones, and becoming suspicious that one is being talked about because you cannot hear what is being said are normal conseqeunces of hearing loss.

In the hearing impaired, attempting to understand verbal communication from a relatively unfamiliar voice (your doctor, for example) can be a strain. If the physician does not know about the hearing loss or does not adequately accommodate for it, the situation may not only be frustrating but dangerous. For instance, a physician might say to a patient; "You have high blood pressure and arthritis. Both of these conditions are aggravated by the fact that you are 50 percent over your ideal body weight. Here is a 1,000-calorie, low-salt diet you should begin right away. Also, I want you to start on these blue pills. Take one in the morning and one in the evening. For your arthritis, I want you to start on these yellow pills; one four times a day and always be sure you have some food in your stomach when you take them."

The patient with normal hearing would probably want to slow the physician's recital and say, "Now, wait a minute. What did you say? Back up and let's go over that again." If, however, the physician is trying to communicate with an older patient who has impaired hearing and does not recognize or understand how to deal with the problem, she may feel overwhelmed or ashamed by the inability to make her needs known. Consequently, the patient gives up in disgust, waits until the physician leaves the room, and then asks the nurse, "What did the doctor say?" Further, the patient could conceivably go home without asking for clarification from anyone in the doctor's office.

As with vision, there are also medical conditions which cause impaired hearing. Some of these may be helped by a hearing aid, but some may not. It is important to understand that a conventional hearing aid amplifies all sound, including background noise, and may lead to more aggravation than assistance (*4*).

Another important component of sensory loss is that of touch. While it is true that sensitivity to touch is diminished as one ages, the primary loss in this modality originates with the physician. Doctors, in general, have a reluctance to touch patients unless they are doing an examination, performing a procedure, or are otherwise engaging in some function requiring physical contact. Undoubtedly, many physicians are more reluctant to touch an old body. A valuable tool in effective communication is the use of therapeutic touch; a hand on the arm or shoulder can help gain the patient's attention and keep it focused (*5*). Such action lets the patient know that the physician is listening or that the patient needs to be particularly careful to listen to what the physician is saying. This is a simple and effective communication modality, and when used appropriately, is nonthreatening.

One further decrement that may take place is a general sensory decline, which reduces sensitivity to signals of illness such as pain, pressure, cold, and heat, and it behooves the practitioner to be especially cognizant of this fact when dealing with the elderly.

Language Problems

A second aspect of communication barriers is that of language, specifically doctor language versus patient language (*6*). Physicians often feel that they work very hard over a long period to acquire a very difficult, very expensive, very precise vocabulary. Once the language is mastered, students and physicians feel impelled to use it. They may feel that they are making an undersirable concession by speaking to the patient in her own language. In spite of the best efforts to teach good interviewing skills, use of open-ended questions, and empathic listening while in medical school, most students and physicians resort to a rapid-fire, jargon-filled communication technique when taking histories and giving patient information. Interrogation and indoctrination of the patient might be more appropriate terms for these activities than interview and explanation.

Psychosocial Factors

The third category of barriers may be characterized as psychosocial factors, of which one important component is the belief in negative stereotypes. Physicians and patients alike fall prey to the allure of communally held images. Negative stereotypes toward women abound in society, particularly in re-

gard to older women. Doctors are affected much more by the societal and parental values of their upbringing than by their medical education (*7, 8*). Unfortunately, medical education sometimes reinforces and perpetuates negative images of women as chronically ill neurotics who are hysterical and demanding (*8*). An older woman may fear being labeled a nuisance, a hypochondriac, or a "crabby old woman" and so may underreport her symptoms. Conversely, doctors who have an automatic reaction to older patients as being beyond their ability to "cure" may shrug off the patient who is making an honest effort to report appropriately. The physician may respond to the patient's complaints with a phrase such as, "Well, what do you expect at your age?" This is a very effective deterrent to further reporting of information from the patient.

Stereotypical role-playing behavior can also be a potent inhibitor of open communication. Many older women are intimidated by doctors and see them as godlike creatures who are busy with important matters and should not be bothered by something as trivial as a pain in the knee, feeling blue, or wetting yourself accidentally. They may be very timid about giving information which they consider private or embarrassing, may feel rushed, or simply may not know how to give information in a way that they think the doctor will find acceptable. They are also prone to accept poorly communicated explanations and feel that they are the ones who are at fault by being ill, old, and confused. Regrettably, there are still a large number of doctors who are willing to see themselves in the deity role.

For lack of a better alternative, the older woman may be willing to play the stereotypical role of an old woman. Accepting aches, pains, depression, and other problems as a normal part of aging and failing to mention them can be common occurrences. There is much confusion in the general population as well as in the medical community regarding "normalcy versus disease" in relationship to aging. In contrast to those who underreport their symptoms, there are those who overreport symptoms. Some are so fearful of even the slightest ailment as a sure sign of "the beginning of the end" that they psychologically drive away the physician. Slipping into the old woman role may sometimes be perceived as easier than viewing oneself as healthy, productive, caring, and worth being cared about. The positive view implies certain responsibilities for one's own health care.

Finally, the physician and the patient may have differing priorities. As individuals age, the retention of functional abilities takes on greater importance in the maintenance of self esteem, i.e., that is, the ability to perform routine activities of daily living such as dressing, toileting, eating, driving a car, keeping a home, balancing a checkbook, and so on. It may be less important to a widow who lives alone to be given a label for her disease than to be given some extra time exploring the meaning of the disease to her way of life. A diagnosis of terminal illness to a frail patient of 90 years may mean less to her than a discussion regarding the realities of how she will be able to function during the life remaining to her. Physicians tend to have a definite bias toward being "disease oriented" and often overlook the ways in which the disease affects the patient. Both provider and consumer may become entrapped by the belief that prevention and wellness are not realistic goals for older women (*1*). They may fail to pursue avenues to postpone disability and immobility. Finally, personality factors are a significant ingredient in the doctor-patient relationship (*9, 10*). Finding the right match between physician and patient is as important to communication as any arbitrary standard set by outside influences.

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