# Panel Session: Management/Education

## Panel Summary

ADA SUE HINSHAW, PhD, RN, FAAN

Dr. Hinshaw is Director, National Center for Nursing Research, National Institutes of Health, Bethesda, MD. Dr. Hinshaw served as the Moderator of the panel "Management and Education" at the FDA Special Topic Conference on Osteoporosis, sponsored by the Food and Drug Administration, held at Bethesda, MD, October 30, 1987. This article is a summary of the panelists' presentations.

THREE MAJOR ISSUES surfaced from the panel discussion on management and education:

- The appropriateness of extrapolating research findings from the younger-than-70-year-old woman to the over-70-year-old-woman was questioned, both in terms of the knowledge available, and the suitability of using identical treatment regimens.
- The information available to consumers and primary care physicians concerning osteoporosis, its prevention, and various interventions was assessed and judged lacking in several key areas.
- Educational and counseling strategies for obtaining informed consent and for motivating individuals to prevent, treat, and adhere to treatment regimens were identified for use by health care providers.

The Resnick and Greenspan paper, entitled "Osteoporosis in the Older Female: A Reappraisal," raised numerous questions about the applicability of research findings on the female under 70 years of age to the prevention or treatment of osteoporosis in the female of over 70 years. A number of physiological differences were enumerated which would suggest that the usual regime for osteoporosis as tested for the under-70 population could be either contradictory, or extremely expensive for the over-70 population. This argument led Resnick and Greenspan to question the traditional treatments, including the prescription of calcium supplements, estrogen therapy, and exercise programs, for the female over 70. Specifically, these regimes were questioned for individuals over 70 who had not been enrolled in prior prevention and treatment programs for osteoporosis.

A principal recommendation of Resnick and Greenspan was that for the female over 70 years of age, the prevention of osteoporosis may be best measured in incidence of fractures rather than by more traditional methods. They recommended the cautionary use of traditional treatments, and more emphasis on strategies to prevent falls in the over-70 female, e.g., supportive footwear, and careful placement of rugs and furniture within the home environment.

Resnick and Greenspan's paper prompted many questions from members of the audience, who were primarily seeking definitive answers to the question of the need to use calcium supplements versus only dietary provision of calcium, and the amount of calcium needed by the frail, elderly female. The discussion confirmed the complexity of this issue, and the lack of research conducted in a suitable population, i.e., females over 70 years. Dr. Resnick and other experts agreed (with reservations) to the use of calcium supplements, reiterating the amounts which had been agreed upon at an earlier consensus conference on osteoporosis, i.e., 1,200 milligrams (mg) for the female adolescent, 1,000 mg for the pre- and postmenopausal female, and 1,500 mg for those individuals in the elderly age span. While providing this treatment advice to the audience, the panel and other experts emphasized the need for research on the frail, elderly female population (over 70 years) to test the questions being raised about calcium supplements, estrogen therapy, and exercise programs.

A second major issue discussed by a panel participant, Dr. John Renner, was an assessment of the amount of information known by consumers and primary care physicians about the prevention and treatment of osteoporosis. In Renner's survey, 733 consumers who responded judged osteoporosis to be a serious disease; 60–66 percent of them were attempting to prevent osteoporosis, or thought that it was preventable. However, this suggests that 34–40 percent of these consumers were not aware that osteoporosis can be prevented. This figure was of concern to Renner, since he judged that the persons who responded to the survey (12 percent of the potential participants) represented a group of consumers who probably have a strong interest in osteoporosis. Of this group of consumers, a relative-

ly high percentage (68 percent or more) were aware of or involved in some form of prevention mechanisms, i.e., calcium supplements, dietary calcium, or exercise. The major finding that Renner emphasized was the 52 percent of consumers who were postmenopausal women and not using, or aware of, estrogen therapy for the prevention of osteoporosis.

Of the 761 primary care physicians who responded, 77 percent judged that osteoporosis was preventable, and a number of them believed that the time to start prevention regimes was adolescence. Dr. Renner was concerned about the 25 percent of these physicians who do not believe that osteoporosis is preventable.

The questions which Dr. Renner raised were: What type of information, and strategies for conveying information, can be used to educate both consumers and physicians about the prevention of osteoporosis and the various treatment regimes which are available? Renner was particularly interested in the number of patients who, physicians stated, were receiving estrogen replacement therapy, which ranged from 75 to 100 percent of the patients attended by obstetricians/gynecologists, to a smaller percentage attended by internists. The survey raised additional questions about the treatment being prescribed by primary care physicians.

Based on the results of the survey, Renner reported that consumers and primary care physicians are aware of osteoporosis, its prevention, and treatment. However, two issues need to be considered: (*1*) most women need more calcium, added either by diet or supplements, and (*2*) an "estrogen gap" exists, i.e., a number of individuals are not receiving estrogen therapy for a variety of reasons. Renner contended that information provided to the public and to primary care physicians can be confusing, and that it is important for the research community and medical experts to clarify the messages on osteoporosis, its prevention, and treatment.

Dr. Bartlett's paper, entitled "Patient Counseling for Osteoporosis Prevention," started with the assumption that knowledge is a necessary, but not sufficient, condition for individuals to adopt prevention or treatment strategies when confronted with osteoporosis. Two fundamental problems exist when applying the traditional, well-researched patient counseling and educational base to assessing and advising clients about osteoporosis. One problem is informed consent, or agreement to enter into the prevention and treatment of osteoporosis. This informed consent and agreement is basic to the patient's motivation and later adherence to any type of treatment regime. Bartlett recommended that the advice

*'This informed consent and agreement is basic to the patient's motivation and later adherence to any type of treatment regime.'*

be behaviorally specific for the particular problems that the client foresees in either preventing the disease, or adhering to the treatment of osteoporosis. A set of guidelines was proposed to help health care providers obtain informed consent and involvement from patients.

The second problem is adherence to either prevention or treatment regimes for osteoporosis. Bartlett outlined the traditional regimes used and identified common barriers for clients in following such regimes. In addition, a series of enhancing methods were recommended for each regime. In response to a question raised during the discussion, Bartlett mentioned strategies which can be used to facilitate the client's own self-care behavior in relation to osteoporosis.

In summary, a number of questions were raised concerning the application of current knowledge of osteoporosis prevention and treatment to unique populations, such as the woman over 70. Questions were also raised about osteoporosis in men, since most of the conference focused on women. Information was provided on the level of knowledge of lay people and primary care physicians about osteoporosis prevention and treatment. A series of educational and counseling strategies was advanced, in addition to a set of adherence-enhancing methods.