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Original Article

Patient-Physician Communication During Medical Visits: Senior Adults' Perspectives, Expectations, and Experiences

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Abstract

Background: Patient-physician communication is among the most important aspects of health care. Studies have shown the impact of such a communication on patient safety, patient satisfaction, treatment adherence, and malpractice lawsuits. Patient-physician communication is even more important where the patient is an elderly adult. The age-related physical and cognitive issues as well as some other factors impact elderly patient-physician communication in a negative manner.

Objective: The aim of this study was to investigate senior adults' perspectives, expectations, and experiences regarding communication with their physicians during medical visits.

Methods: The study used a mixed-method approach, including quantitative and qualitative methods. 73 senior adults, age 65 and over, participated in this study. In the quantitative method, a survey was conducted, and the qualitative method included several face-to-face, semi-structured, and open-ended interviews to obtain the participants' viewpoints and experiences in a more explanatory manner. The study was conducted in Los Angeles County in the United States.

Results: All the subjects believed that senior patients have particular needs and expectations during medical visits that should be taken into consideration by physicians. Moreover, the findings of the study

revealed the subjects' particular needs and expectations as well as their specific experiences regarding their communication and interactions with their physicians during visits.

Conclusion & Implication: The findings of this study can help physicians to better understand their senior patients' attitudes and expectations. This will enable them to communicate and interact with this group of patients in a more effective way.

Keywords: Ageism; Information Exchange; Patient-Physician Communication; Senior Patient; Elderly Health Care; Trust, Empathy, and Rapport; Physicians' Age, Gender, and Ethnicity; Language Barrier; Medical Information Restating

Abbreviations: CDM-Collaborative Decision Making

1. Introduction

1.1 Theory base for research

In the past, patient-physician relationship was often modeled based on agency theory [1,2,3]. This theory, which focused on separation of control and ownership, indicated the need for implementing a mechanism to resolve the conflicts between a principal and an agent [2]. A one-sided patient-physician relationship, from the more powerful entity (physician) to the less powerful entity (patient) was the dominant view in the past [4]. Since then until now, a variety of models for such a relationship have been conceptualized. Many researchers believe that in comparing and evaluating these models, one important criterion should be the extent to which they reflect *the goals of medicine* [5].

The goals of medicine have been highly discussed in the current literature on health care and patient-physician relationship and communication. One famous researcher in this area is Eric Cassell who has conducted several studies, and has authored numerous articles and reports related to the goals of medicine. An effective model of patient-physician relationship and communication can help to secure the goals of medicine through promoting patient wellbeing. *Patient autonomy* is the other concern raised in the existing literature on patient-physician relationship and communication. According to [6], two factors that make autonomy relevant to patient-physician relationship are the instrumental value and intrinsic value of autonomy. The instrumental value is associated with "the right to self-sovereignty" [5,7]; and the intrinsic value is associated with the behavioral and psychological aspects of autonomy, which is considered as "a condition of persons" or "a quality of persons" [5,6].

One of the patient-physician communication models which reflects both concepts of the goals of medicine and patient autonomy is collaborative decision making (CDM). This model has been highly advocated by many research studies in the existing literature. In a CDM model, instead of just a unidirectional communication made and directed by the physician, a strong emphasis is made on a bidirectional and meaningful dialogue between the patient and the physician [8]. The four major characteristics of CDM are: (1) involvement of at least two participants: the patient and the physician; (2) information sharing by both parties; (3) reaching a consensus on treatment; and (4) reaching an agreement on how to implement the treatment [9].

Some of the main advantages of CDM over the other models are being more ethical, more practically functional, and highly supported by patients [5].

One other theory, related to this study, pertains to *ageism*. Social constructionism theories and the research studies associated with them provide us with an understanding about development of attitudes and actions regarding older individuals [4]. Knowing about the existing theories of social constructionism will help us to better understand senior patient-physician communication. Ageism is a systematic stereotyping against people based on their age. The term "ageism" was initially coined by Robert Butler in 1968. He defined ageism as "prejudice by one age group toward other age groups." Butler's argument indicates that the lack of knowledge as well as inadequate interaction with elderly adults cause such negative attitudes. Ageism is an important concept in elderly patient-physician communication.

1.2 Importance of patient-physician communication

Relationship and communication between patients and their doctors are among the most important aspects of health care. As stated by [5], "the practice of medicine is not just about technical skill, but is also centrally about people, about relationships, and the need for good communication" (p.100). In the United States, the patient-physician relationship has received high attention since the onset of managed care in the late 1980s [10]. In the current literature, a large number of studies have investigated the nature of the physician-patient relationship and communication, the associated changes made over time, the reasons of these changes, and the existing barriers and deficiencies in this type of communication. Furthermore, in the existing literature there are numerous research studies demonstrating the considerable impact of patient-physician relationship and communication on patient safety [11-23], patient satisfaction [10, 24-35], treatment adherence [10, 26-35], and the risk of malpractice lawsuits [10, 36-39].

1.3 Ageism and elderly patient-physician communication

As stated before, in recent decades both ageism and patient-physician communication have been highlighted in the literature in a considerable manner. For several reasons the discussions of patient-physician communication pertaining to the elderly are more important than those relating to the other groups of patients. Some of these reasons include: (1) the existing challenge of the aging population in the United States and the rising costs of that; (2) the fact that elderly patients usually suffer from multiple diseases; and (3) various barriers among the elderly pertaining to their cognitive deficits and weakening abilities in vision and hearing [40-42].

When we are in a communication process, our perception about the person with whom we communicate has an important impact on the process. Moreover, researchers have shown that communication behavior of people is influenced by the attitudes and expectations they bring to the communication [4]. It is also argued that a variety of factors, such as the ways of the information processing, environmental and interpersonal situations, and intergenerational aspects influence a communication process [4, 43].

In the current literature, there are many studies indicating that some of the elderly patients are feeling a kind of ageism against themselves by their physicians. For example, a study found that its subjects, elder patients age 70 and older, were experiencing lack of empathy from their doctors, poor results caused by information self-disclosing, a feeling of being objectified by the doctors, and a lack of perception of control pertaining to their own health care [2].

1.4 The aim of the present study

The aim of this article was to investigate perspectives, expectations, and experiences of senior adults regarding their communication and interaction with their physicians during medical visits. This article is based on the investigator's doctoral dissertation research which was conducted at Claremont Graduate University.

2. Materials and Methods

2.1 Methodology

The present study used a mixed-method approach, including quantitative and qualitative methods. The reasons behind the combination of these two methods were: (1) quantitative method could provide a scientific approach facilitating an effective way of data gathering and studying the phenomenon from a distance, and (2) qualitative method could make it feasible to provide a deeper and a wider-angle lens to look at multiple dimensions of the phenomenon in an open-ended and flexible manner. Furthermore, the descriptive nature of qualitative data could provide a better understanding of the overall picture. The quantitative method used a survey, and the qualitative method included conducting several face-to-face, semi-structured, and open-ended interviews to obtain the participants' viewpoints and experiences in a more explanatory manner.

2.2 Participants

73 senior patients, age 65 and over, participated in this study. It was conducted in the Southern California. Most of the participants (64.4%) were residing in senior/retirement communities, and the remainders (35.6%) were living in their independent residences in the area. Table 1 shows demographic characteristics of the participants.

2.3 Study sampling

In the present study, subjects were selected based on *purposeful sampling techniques*, introduced by [44]. The criteria for selection of the subjects were: (1) being age 65 or over; (2) having the experiences of several interactions during doctors' visits in the last few years; and (3) being able to understand and speak English. Moreover, in conducting interviews, the study used *convenience sampling* which was based on the voluntary attendance of participants in the interviews.

Demographic Characteristics	%	Demographic Characteristics	%
Age Groups		**Gender**	
65-74	35.6%	Female	56.9%
75-84	42.5%	Male	43.1%
85-94	21.9%		
Employment Status		**Level of Education**	
Part-time employed	2.8%	High school/GED	9.6%
Retired	87.5%	Junior/community college	12.3%
Self-employed	2.8%	Undergraduate college	20.5%
Unemployed	4.2%	Graduate School	43.8%
Disabled	2.8%	Post-graduate (PhD, MD, etc.)	13.7%
Ethnicity		**Annual Household Income**	
Native American	2.7%	Less than $20.000	10.1%
African American/Black	4.1%	$20,000-$39,000	23.2%
Caucasian/White		$40,000-$59,000	21.7%
Middle Eastern	6.8%	$60,000-$79,999	15.9%
Non-Middle Eastern	78.1%	$80,000 or more	29.0%
Latino/Hispanic	4.1%		
Asian/Pacific Islander	4.1%		
Marital Status		**Health Status**	
Single	6.8%	Poor	2.7%
Married	60.3%	Fair	21.9%
Divorced	5.5%	Good	37.0%
Widowed	23.3%	Very good	30.1%
Living with partner	1.4%	Excellent	8.2%
Never married	1.4%		
Prefer not to answer	1.4%		
Living Place		**Having any chronic diseases / health problems**	
Live in retirement/senior communities	64.49%	No	32.9%
Live in independent house	35.6%	Yes	67.1%
U.S. Citizenship	100%	**Having a Health Insurance**	100%

Table 1: The Participants' Demographic Characteristics

2.4 Recruitment resources

Two complementary approaches were used for recruiting subjects: (a) through some of the retirement/senior communities in the area; (b) direct recruitment. In the first approach, the investigator contacted the administration offices of 5 senior communities and retirement centers in Los Angeles County area, requesting them to distribute the survey questionnaires among their residents or community friends (among those individuals who met the inclusion criteria). The selected senior communities were:

1. Pilgrim Place (Claremont)
2. Claremont Manor (Claremont)

3. Mt San Antonio Gardens (Pomona)
4. Hillcrest (La Verne)
5. Joslyn Center (Claremont).

In the second approach, a limited number of participants were recruited directly. This group of participants received the surveys via email, mail, or in person.

2.5 Data collection

Data gathering, which lasted 11 months, was done through surveys and in-depth interviews. The response format of the survey items was a 5-point Likert-type scale, with the five response options as strongly disagree (1), disagree (2), neutral (3), agree (4), strongly agree (5). 73 surveys were completed by the participants. Qualitative data was obtained through open-ended, semi-structured and in-depth individual interviews. The semi-structured form of interviewing provided a good opportunity to gather the required data in a flexible manner. Among the participants, a total of 20 volunteered to be interviewed. Locations of the interviews were chosen based on the preferences of the interviewees. Interviews were scheduled by the administrative staff of the senior communities, through email, or by person. A reminder - through a phone call, email, or text message - was made the day before the interview. Each interview lasted about 60 minutes, and was recorded.

3. Results

3.1 Senior patients' particular needs and expectations during doctor visits

In one of the questions in the survey, the participants were asked if they believed that senior patients have particular needs and expectations which should be taken under considerations during medical visits. All the participants gave positive response to this question. Additionally, in another part of the survey the subjects were asked about their own needs and expectations during visits. Table 2 demonstrates their important needs and expectations (the mean values of the responses have been demonstrated).

In addition, the qualitative results obtained in the interviews showed that all the interviewees believed that due to the chronic diseases and the age-related physical/mental changes, senior patients have particular needs and expectations from their doctors during visits. Following, some of their explanatory responses in this regard are listed.

"Senior patients have particular needs. I strongly agree with that.…"

"Yes, of course [seniors have particular needs and expectations]. Well, I think that physicians need to be aware of the physical decline of elderly patients, hearing loss, chronic illnesses, mental decline, … these kinds of things…, they can't expect the same kind of response. I think there is a difference at the moment [between] the way seniors interact with their doctors and the way younger patients interact with their doctors. And, doctors need to be sensitive to that… and, sometimes, in some cases, longer visits are needed."

"We think that not only geriatric doctors, but also all kinds of doctors should know more about seniors and know their needs. Especially [about] seniors in higher rate of age (like 85+ year old people)."

"Yes, I do think so. I think seniors have individual problems. That's why I think seniors need doctors to know enough about seniors and senior health care… we need geriatric doctors... My primary care physician should not be an ordinary primary care physician, he should be a geriatric primary care physician."

"I think that for those senior persons who are suffering of age-related cognitive or other problems, it could be true that they have different needs and expectations than younger ones. And, [in particular,] the medication would be the area that can be most problematic. I think the doctor needs to be aware of hearing difficulties; and, if there is a hearing difficulty, making sure that the person is understanding what he/she [the doctor] is saying; [and, if] the things are clear; [and, if] the patient really knows what the doctor says to do."

"I think seniors have special needs. The fact is [that] their body is changing, …Their medication [also] needs to be monitored more closely because it would be easy for seniors, on some medications, to not take the medication properly. I think they look to their doctor to help them on that. Help them not only to watch out for side effects …but to give them verbal information about what might happen to them, what might interact [among the medications], and what they should not do…"

"For senior patients, understanding is very important… In many cases, more clarification is needed. Some patients do not hear very well, and some doctors do not speak very laud; and also, some doctors have accents. And, sometimes, we are so nervous, and we forget some very important things…so, patients need to ask questions if they don't understand something… We [also] need more time."

"Here, in the United States, people are from different cultures, there are millions of people, all from different cultures, …and they have different expectations from their doctors."

3.2 Listening, dialogue, and information exchange

As shown in Table 2, the quantitative results shows that the subjects expect their physicians to listen to them carefully, provide them with a suitable environment for a two-way dialogue, and explain to them about their health issues and the treatment. Moreover, Table 3 demonstrates the subjects' responses to the questions pertaining to the extent to which these expectations are met currently by their own doctors.

The data obtained in the interviews supported the mentioned results as well. Below, some of the interviewees' responses are provided.

"…Absolutely we need more information, more explanation, and longer visits. Seniors need more time, they want to hear… they also want to ask some questions, and clarify [to make sure] if they heard correctly…"

The Participants' Expectations ***I expect the physician to*:**	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Number of Responses	Mean
	1	2	3	4	5		
Provide an open environment where I can ask what I need to know						72	4.86
Listen to what I say						73	4.84
Provide suitable explanation about my health and/or treatment						73	4.77
Explain my health problem clearly and using simple words						72	4.71
Make eye contact with me during conversation						72	4.68
Engage me in a two-way dialogue						71	4.65
Provide me some contact information (phone number, email address, etc.) to communicate with him/her directly, especially when the office is closed						70	3.97
Provide longer visits						71	3.39

(1: Strongly Disagree, 2: Disagree, 3: Neutral, 4: Agree, 5: Strongly Agree)

Table 2: The Participants' Important Needs and Expectations During their Doctor Visits

"Listening to patients is very important. Generally, I'm not gonna back to a doctor who doesn't listen to me, the main thing I would look for. I think there are some doctors who discounts symptoms of, specially, older women, and they don't wanna deal with that. I don't think younger doctors doing this so much. … I read a book by …. talking about doctors focusing on one symptom and make diagnostic that many times is wrong diagnostic. So, I would look for a doctor who … if I said: 'what else could this be?' I would expect them to think about that, and see if the other things would be… I think a few doctors are who… jump into conclusion, and start to treat. They don't wanna think about it… But, then, I wouldn't go back to them."

"… dialogue and conversation, when we go our doctors, are very important…One of my expectations, which are not always met when I go to see the doctor, is an exchange of conversation or discussion. I expect dialogue and listening. In fact, when I moved here [CA], I scheduled an interview appointment with the doctors … for the purpose of making clear that if the doctor is a person I can converse with, because I don't feel that confident in a doctor that doesn't listen ... I [also] expect shared decision making."

"He or she should make sure that you understand what (s)he is saying. [Also] I think information provision by doctors is important. If my doctor does not do that, I would change my doctor. I did it actually once."

"Yes, information provision by doctors can be very helpful. But, as I said, my doctors don't have the time

to explain something, because, it seems that they are always in a hurry, all the time… And, the Internet is so helpful … giving [us] more details. So, we can use the Internet for that…If I get more information, good explanation about the symptoms that I am having, when I leave my doctor's office, I will have a very good feeling, and more satisfaction."

The Participants' Experiences Regarding their Communication with their Physicians	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**	N (valid)	**Mean**
	1	**2**	**3**	**4**	**5**		
My doctors listen enough to what I say to them						69	4.10
Doctors answer my questions well						69	4.13
The medical information given me by my doctors is understandable enough						69	4.23
I am comfortable asking my doctors questions						69	4.55
Overall, I am satisfied with the way my doctors communicate with me during visits						69	4.26
Doctors provide me enough medical information related to my health problem						69	4.01
Doctors give me enough information about how to take medications						69	3.64
Doctors give me enough information about the potential side effects of the prescription drugs						69	3.29

(1: Strongly Disagree, 2: Disagree, 3: Neutral, 4: Agree, 5: Strongly Agree)

Table 3: Patient-Physician Communication and Interactions – The Participants' Experiences

3.3 Collaborative decision making on treatment

In the survey, all the subjects stated that they want to be involved in clinical decision making on their treatment. Moreover, their responses to the questions asking them about the CDM process during their recent doctor visits are shown in Table 4.

Furthermore, the participants of the interviews also expressed their specific viewpoints and interests in being involved in their own treatment through participating in clinical CDM process during visits. The following are some of their quotes:

"...I expect shared decision making."

"…I absolutely expect my doctors to get me involved in clinical decision making."

"I expect shared decision making…Some doctors are not comfortable with that. And, as a result, there are errors in [their] treatments. I hear too many say I tried to tell the doctor [that] this medicine was doing such and such, and they just said: oh, just keep taking it, and then, … serious problems. I am fortunate that I have doctors that are collaborative decision makers."

Participants' Experiences on Collaborative Decision Making (CDM) *During visits, my doctors:*	**Never** 1	**Rarely** 2	**Sometimes** 3	**Often** 4	**Always** 5	N (valid)	**Mean**
(Regarding gathering data by the physician) Ask about my health problem						70	4.51
Ask about the time the problem started						69	4.38
Ask about the history of the problem						69	4.13
Ask about related or similar cases in my family						68	3.66
Recognize the causes of my health problem						68	3.85
(Regarding CDM related interactions) Provide me enough information about the nature/causes of the problem						67	3.79
Allow me to consult with them about the related online health information that I've already found						60	3.42
Explain to me about different alternatives or options for my treatment						69	3.71
Explain to me about potential risks and benefits of each treatment option						69	3.80
Ask my preferences about different alternatives for the treatment						67	3.19
Make the treatment decisions by considering my opinions and preferences						67	3.82
Want us to reach a consensus regarding the preferable treatment						66	3.62
Want us to reach an agreement on the implementation of the treatment						66	3.85
(Regarding understanding and restating) Ask me if I understand medical information provided to me						68	3.38
Ask me to restate the important information provided to me to make sure I understand it						66	2.33

(1: Never, 2: Rarely, 3: Sometimes, 4: Often, 5: Always)

Table 4: CDM Process During Doctor Visits - The Participants' Experiences

"I am 100% happy and satisfied with health care services I receive. He [the doctor] listens to you, he helps you in making medical decision that is best for you, and I appreciate that."

"…My doctors are very good about that [CDM style]. I have no problems about that. Absolutely, I am satisfied with my doctors' collaborative decision-making behaviors."

"Being a good communicator, and a collaborative decision maker are among the most important factors for a doctor."

"I'm very satisfied with my doctor and his CDM behavior. I have an excellent doctor who is a good diagnostician, and he is good at listening. And, he shares information. He always asks me what I think is wrong… He [also] listens to what I think is happening in my body."

"My doctor gets me involved in shared decision making about the treatment. For example, if I need operation, and there are other options, he discusses with me about that."

"Yes, overall, I am very satisfied with my doctors, their behavior with me, information provision and collaborative decision making. I have had two general practitioners in Claremont for 20 years, and I have been very happy with both of them. I [also] can call my doctor whenever I need to, and she is there… I really do not have any complaints about that."

"Yes, I am [satisfied with that]. Most of my doctors are pretty good about it [CDM behavior]. I mean, they say: 'look, I suggest this treatment, but what you say?' we have pretty good doctors. Today is a good example: I went to my diabetes doctor. The last time I saw him, about three weeks ago, he said: 'All right, let's try this routine with pills and write them down.' So, I wrote them down every day, I took 3 milligrams a day, and I was figuring about the pills I was taking, and I showed him the record, and he said: 'well, you are doing okay, but let's try different doses during the day, and see how that has a pick,', then he said 'Let's try this'. I think this is a collaborative effort."

"I am fortunate that the doctors I have here are very straightforward and answer all my questions. And, they provide me enough information. They [also] share the clinical decision making about my health with me. So, I have no complaint at all."

3.4 Ageism and negative prejudice

Overall, the quantitative data showed that the subjects of this study had not experienced ageism or any other negative prejudice toward themselves, during medical visits (Table 5). The interviewees also explained that they had not encountered ageism during their doctor visits. On the contrary, most of them were very satisfied with their doctor-patient encounter, and with the way their doctors behave with them as senior patients.

The Participants' Experiences Regarding Ageism by Physicians	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N (valid)	Mean
	1	2	3	4	5		
I feel a kind of *ageism* in my doctors' communication with me						69	1.99
I feel that my doctors have a negative prejudice against me						72	1.63

(1: Strongly Disagree, 2: Disagree, 3: Neutral, 4: Agree, 5: Strongly Agree)

Table 5: The Participants' Perception of Ageism Against themselves by their Physicians

3.5 Trust, empathy, and rapport

All the subjects believed that trust, empathy, and rapport are very important in their communication with their physicians. The quantitative results obtained from the survey also showed that the subjects believe that there are trust, empathy, and rapport in their current relationship with their doctors (Table 6).

The qualitative data obtained in the study supports these findings as well. The interviewees emphasized the importance of trust, empathy, and rapport in senior patient-physician communication. They also stated that there is a high level of trust, empathy, and rapport in their current relationship with their physicians.

Trust, Empathy, and Rapport	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N (valid)	Mean
	1	2	3	4	5		
I trust my doctors						72	4.21
I feel my doctors trust me						72	4.17
My doctors listen to me when I express my feelings						72	4.11
My doctors are interested enough in my concerns						69	4.00
I care about my doctors						71	3.97
I feel there is a bond between me and my doctors						72	3.92
I feel I have a close relationship with my doctors						71	3.52

(1: Strongly Disagree, 2: Disagree, 3: Neutral, 4: Agree, 5: Strongly Agree)

Table 6: Trust, Empathy, and Rapport – the Participants' Perceptions and Experiences

3.6 Physicians' age, gender, and ethnicity

3.6.1 Physician's age: During the interviews, participants expressed their viewpoints regarding the age of their physicians:

"We [my husband and I] both have been changing sometimes our physicians. We were kind of looking for younger doctors...because, younger doctors have most recent education. And, their information is probably newer than older doctors. They are more up-to-date."

"Age, oh…, younger doctors have a more direct approach. Older doctors know how to get the information at the same time [causing] the patient to feel comfortable and to exchange. But, they both make their goals. I don't have any preference to age and nationality."

"I think age is important. I think their training [doctors' training] is different. And that makes a big difference. I think in general it is true that younger

doctors are more updated. Plus, we don't wanna outlive our doctors. … So, you need to look for younger doctors… If I want to choose a doctor, I prefer a doctor in the age of 40s because they have experience but still they are fairly young. [But] there are some exceptions too. There are some, for example, older doctors who are really good; very updated...also I think some of them [differences] are personality type. … So, it's not just the matter of age."

"I found that younger doctors seem to be more interactive, but what I don't like, and sometimes see is [they] say I'm the doctor, don't mess with me. I'll tell you what to do… Don't be too involved in this, because I'm gonna tell you."

"No, I don't think [age is influential]."

"Well, the older doctors, I mean, they don't even talk to their patients. When I was younger, I had an old doctor, he was so… the new doctors are a little better than that, but still I think because they went to medical schools, they think that they know what's right. In some cases I would agree, but, I would also like to look at all alternative things, and medical doctors don't wanna do that. They wanna stick put on the pills [while] I want sometimes to take [for example] ginger roots or something, yeah… So, there is always that, I always feel some disconnection…."

"Young and old! I can give you an example. I had a surgeon, I didn't pick him up, my primary physician said go to him, he is the best one. He was an old guy, an old doctor. And I thought it was because of his age, he thought that he knew everything, and he didn't even want to consult, [saying] just do what I say… and he didn't really want to talk about it. So, I decided to go to another doctor, younger maybe, … Maybe that is my bias because of the way he treated me, and generalized from that doctor to [all] the older doctors. I don't know. On the other hand, my primary physician, died and …So, that is why I am concern about age."

"Generally, I think these attributes are important, but other factors like personality are important too. I prefer someone who is open and listener, and is willing to repeat, explain again, if I ask when I don't get it."

3.6.2 Physician's gender: In the survey, the subjects were asked about the gender of physicians and its potential impacts on their communication with them. Their responses indicated that the gender of their physician had no significant impact on the communication with them.

Furthermore, in the interviews, the participants expressed their viewpoints in this regard with more explanation. The following are perspectives of three female interviewees:

"No, I don't think so [that physicians' gender is important]. The important thing is how they treat me."

"I found that women [female doctors] are much more open to talking. I think the women can reach out for the emotional reactions trying to tie into that. My doctor is giving me a hug, couple of times. Good

relationship… Yes. That is very important…But a man might be not so easy about that."

"The most important thing for me is that the doctor should be a good diagnostician. I don't care about the gender of a physician, except for gynecologist. I want my gynecologist to be female. I do think that women gynecologists understand women better…I just look up where the doctors have been trained, where they have studied. That is important to me. I want the person to be a board certified, to really like what they do, and to be a good diagnostic. I don't think that age, gender, or ethnicity are important."

3.6.3 Physicians' ethnicity and the issue of language barrier: One of the questions in the interviews was about the ethnicity of the physicians and the potential language barriers. Here are some of the responses:

"I think ethnicity is very influential on communication. Sometimes we have problem because of language barrier……And that is true that here in CA, many doctors are from other countries, with different ethnicities… My doctor [for example] is from India. Sometimes we have problem because of language barrier. I think a solution [for that] is the patients have to take more responsibility to do what they can to make sure they understood the doctor. Asking questions, and perhaps asking someone else come with you (advocate). The doctor has the responsibility too, to be aware that he might not understand … of what the person will be willing to tell him, and so,….they have to sort of guess sometime what the problem is!"

"Language barrier is one of the critical issues in health care system, specially, here in the Southern CA. Here there are a tremendous spread of the ethnic backgrounds and people from all over the world, both in patients and physicians. Most of our physicians here are from other countries, and some of them have accent that makes patient-physician communication hard. Also, many patients are from a variety of ethnic backgrounds. Language barriers cause many problems."

"I think many older people find it harder to understand someone who may have an accent because they come from a different place of the world, whatever, and sometimes I think people stop trying to understand...oh, I can't understand him, you know, so, they just don't try anymore. But I think if you repeat to the doctor… this is what I think you said, then, that really helps."

"Choosing a good doctor who meet the specific expectations of a patient is very important. Patients should have the possibility of interviewing a doctor in order to decide to choose her/him as their physicians, especially primary physicians and internists. Patients need to make sure about if the doctor:

- Has appropriate attributes (characteristics) from the standpoint of culture, ethnicity, education,
- fully listens to what their patients say to them
- Uses an appropriate language (many doctors talk down- e.g., water pill instead of diarrhea."

"We [my wife and I] haven't found any problems with ethnicity, and with age either. And I have a lot of personal experience and opinions of very positive. Because of where …here right now, a number of people, from all over the world, from India, from other parts of South Asia, and we have people almost from any parts of the world.… We think being a good communicator, and having collaborative decision making style are among the most important factors for choosing a (new) doctor."

"No, I don't think ethnicity is important [in influencing doctors' characteristics] … But, it might be specific times the doctor should know, have an idea, that a particular patient may not understand, because of language barriers or whatever, that he needs to be more, ah.., make sure that the patient understands what he is saying ."

"I don't think that these attributes would affect my doctors' behavior, communication, and CDM behavior. Our doctors are of different ethnicities, and we haven't had any problem with them."

"No, I don't think so. The important thing is how they treat me."

"No, that's an individual thing. … I don't think that ethnicity is important."

"I don't think nationality has any impacts on physician behavior."

4. Discussion

Patient-physician communication is an important factor in providing high-quality health care services. There are numerous studies in the existing literature indicating the importance of patient-physician communication and its impact on patient safety, treatment adherence, patient satisfaction, and lowering the risk of malpractice. On the other hand, for elderly patients, due to their age-related physical and cognitive issues, communication with physicians is even more important than other patients. The aim of this article was to investigate senior patients' perspectives, expectations, and experiences regarding their communication and interactions with their physicians during medical visits. Some of the important findings of the current study are discussed as follows:

-All the participants in the present study believed that elderly patients have particular needs and expectations that are required to be taken into account by physicians during visits. They argued that these needs stem from their age-related weaknesses and changes (both physical and mental). This finding is consistent with the literature, where several research studies have highlighted these specific needs and expectations [45-53].

-All the subjects emphasized the importance of clinical CDM. They expressed their eagerness to be involved in their own treatment process through CDM. This finding is not in agreement with some other studies in the literature which argue that CDM is not desirable enough among senior patients [47, 49,51].

- Listening, dialogue, and information exchange were the other concerns of the participants. They believed that physicians are expected to listen carefully to

senior patients and provide them with an open and comfortable environment for a two-way dialogue during visits. They argued that such a dialogue is important in conversing about the symptoms, other medications the patient is taking, different health issues they suffer from, and more. They also emphasized the importance of information provision by doctors during visits, while stating that one issue in this regard would be the length of visit time.

- Understanding was the other concern of the senior participants. They emphasized the impact of their understanding of medical information provided by physicians on the effectiveness of the communication process. This finding is in line with several studies in the literature that highlight the importance of patient's understanding during doctor visits. As an example, one of these studies demonstrated that many patients leave their physicians' offices without required understanding, and in some cases with a misunderstanding about their health problem or the treatment [54]. Moreover, several studies argued that after visits, a high level of medical information is lost by patients, ranging 46 - 63 percent [55-60].

- The subjects also believed that to address the issue of the medical information understanding, one effective mechanism could be restating of important information. This is consistent with the findings of several studies [54, 61]. Surprisingly, the participants stated that their physicians never asked them to restate the medical information to make sure about their understanding.

-Trust, empathy, and rapport were the other concerns of the participants. In particular, many of the participants believed that the physician rapport with patients is a critical factor in their communication with physicians. On the other hand, many of them believed that one issue which impacts the physician rapport is the insufficient time of visits.

- As mentioned above, the findings of this study indicates that one issue in senior patient-physician communication is the length of medical visits. This finding is consistent with the literature where several studies highlighted the issue of the short time dedicated to a visit [10,34,36, 62-64]. One of the main reasons of this issue in the United States is the existence of cost containment strategies. Such strategies put pressure on physicians to see more patients in a day. In such a circumstance, a physician cannot spend enough time for a patient visit. It should be also mentioned here that regarding the length of visit time, some participants of this study believed that some senior adults may not necessarily require longer visits. Noting this, they suggested that it would be better if just more flexibility in time duration of senior patients' visits can be taken into consideration. So that if a senior patient needs longer visit, he/she can request for that.

-The age, gender, and ethnicity of physicians, overall, were not important concerns of many of the participants. However, there was only one exception: language barriers. Many of the subjects believed that language barriers can be among serious issues in senior patient-physician communication. They also believed that it is usually a consequence of ethnicity variation. Many of the interviewees argued that it can negatively affect the patient-physician communication and patients' understanding of

medical information. They believed that at the time being, this issue is an important challenge in the United States, especially in the Southern CA, where there is a high variation of ethnicity among the practicing physicians.

The findings of the present study should be viewed in the context of some limitations. First, the study was conducted in a limited geographic scope in Los Angeles County in the Southern California. Because of some constraints, such as time and budget limitations, it was not feasible to gain access to a larger geographic scope for the study. The second limitation was related to the selective sampling of participants. Data gathering was done mostly in five retirement and senior communities in Claremont and the nearby areas where most of the residents were white ethnic, highly educated (more than 50% of them had a Master's or PhD degree), having a relatively high level of annual income, and overall, being in a good health status. To overcome such limitations, there must be more research studies in the future conducted in a wider geographic scope (preferably in a country-wide scope), using a random selection of elderly patients, and reflecting the ethnic diversity of the population.

5. Conclusion

Effective patient-physician communication during visits is among the most important elements of patient care. Such a communication is even more important when the patient is a senior adult. In the present study, perspectives, expectations, and experiences of 73 senior patients, age 65 and over, regarding their communication with their physicians during visits were investigated. The findings of the study can help physicians to communicate and interact with their senior patients in a more effective way during their visits. Following, some of the important findings are highlighted.

Key points & findings:

- Due to the age-related physical and cognitive changes/weaknesses, elderly patients have some particular needs and expectations that should be considered by their physicians during visits.
- The participants of this study believed that all doctors, not just geriatric physicians, should know enough about the care of older adults.
- The physician rapport with patients was highly demanded by the participants.
- The participants had not experienced any negative prejudices indicating ageism against themselves during their doctor visits.
- Although overall the subjects were not very concerned about their physicians' age, gender, and ethnicity, many of them complained about the language barrier as an important issue related to the ethnicity of some of their doctors.
- All the participants were interested in being involved in the CDM process regarding their health problems and the treatment.
- The subjects of this study were not satisfied with the provision of medical information by their doctors during visits, especially information regarding medications and their potential side effects.
- Additionally, many of the participants complained that their physicians never check their understanding about important medical information provided to them. They believed restating of the important medical information can be a very effective way of making sure about their understanding.

- Some participants were concerned about the length of their medical visits. They believed that the time duration dedicted to their doctor visits is not enough. They argued that because of the age-related problems, senior patients' time duration of physician visits needs to be different than the younger individuals. Some other participants suggested flexible visit time for seniors who need longer visits. With considering these points, it seems that the time management strategies regarding senior patients' medical visits need to be revised.

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