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A Review of Geriatric Communication

Morgan E. Ragsdale

Abstract: Communication errors are rampant in our society and no population is exempt from this problem. This article takes a closer look at communication accommodation theories, specifically under and overaccommodation. These are two predominant communication errors that healthcare workers and geriatric patients both experience while working together.

Pharmacists are the liaison between a physician and a patient. As a prospective pharmacist, it is essential I exhibit skills to effectively communicate with patients of all ages. From demonstrating the proper use of inhalers to small children and their guardians, to counseling an elderly patient on how to properly use their blood sugar monitor, pharmacists play a major role in communicating with patients. Throughout pharmacy school, I have discovered communicating and interacting with geriatric patients is a passion of mine. I hope to work closely with this patient population in the coming years, so when the opportunity arose to compose an article about a topic of my choosing, geriatric patients seemed to be a perfect topic. After hearing stories of my own grandma and her friends struggling to communicate with people for various reasons, I wondered if this was a problem in the medical arena. Delving into this question further, I found that hearing loss and cognitive disorders are two major reasons geriatric patients struggle communicating. However, my article focuses on patients who do not have those communication barriers. Instead, this article focuses on communication struggles between health care practitioners and individuals classified as an “older adult.”

My grandma, Patricia Hughes, is an 83-year-old woman who does not have any communication barriers. Despite a lack of barriers, she is frustrated with the way some younger individuals speak to her (PA Hughes, verbal communication, December 21, 2017). “There is an ignorance in how to talk to [older adults].” Her best piece of advice to prevent this behavior is for people to “not expect [older adults] not to be able to understand.” Patricia is not alone in feeling this. As she has aged, altered communication styles have become a prevalent topic of discussion between her and her friends (PA Hughes, verbal communication, December 21, 2017). This is the unfortunate reality that many older adults experience. The assumption that older adults need extra help both in daily life and when consulting with their health care professionals leads to altered communication styles and could potentially lead to medical errors.

As the number of aging individuals continues to increase, communication with the elderly will become even more important. According to the 2016 US Census, 15% of the United States population is over 65 years old.¹ As medicine advances and the healthcare industry lengthens the life expectancy of Americans, we can expect this percentage to continue to rise in the coming years. The increase in the geriatric population is

problematic because many providers lack the ability to appropriately communicate with their geriatric patients.² There are many different types of communication errors that geriatric patients encounter in the medical field. Acknowledging and correcting these various communication errors is the first step in resolving the ineffective communication between providers and patients.

The presence of negative stereotypes in health professionals’ minds presents a fundamental problem in communicating with geriatric patients.³ The perception that elderly individuals are “less competent, more forgetful, slower, more dependent, and less active”⁴ plagues the geriatric community. Elderly individuals may be viewed as “weak, poor, incompetent, and in need of help.”⁵ The reality, however, is that these stereotypes may be representative of a portion of the geriatric population, but they are not accurate for everyone. The idea of frailty and inability within the older generations are prominent in the healthcare community. It is important to discuss these misconceptions in order to prevent miscommunication from hindering the patient-provider relationship.²

The two primary communication errors stem from negative stereotypes: underaccommodation and overaccommodation. Considered communication accommodation theories, these altered styles of communication are used in place of “normal adult speech” which should be used in most interactions that providers have with elderly patients.³ It has been suggested that individuals adjust their speech patterns to allow for greater understanding of material and to narrow the gap between social distances like an age gap.⁶ However, problems arise when healthcare providers change their speech patterns too much, resulting in both underaccommodation and overaccommodation.

Underaccommodation refers to physicians not providing enough information to the patients in a manner that the patient can comprehend.² Underaccommodation results in dissatisfaction with doctors or nurses for their lack of communication and increases the potential for life-threatening consequences.² The patient may not know how to accurately prepare for a procedure or properly take their medications, which can lead to a lack of optimal medical care.⁶ Underaccommodation has been shown to be very prominent in the healthcare field and it is viewed by patients as very unwelcoming.⁶ The lack of communication that is experienced with

underaccommodation does not fall completely on the practitioner; patients can also be guilty of it as well.²

Patients can be underaccommodating to the needs of providers in some healthcare settings.² Elderly patients tend to give medical professionals little information about their symptoms and past medical history. This form of underaccommodation can be just as detrimental to the patient's health as underaccommodation from healthcare professionals. Physicians with insufficient information regarding a patient's medical history or current ailments will not be able to make an accurate diagnosis. This may not only prolong the patient's discomfort, but also lead to increased patient visits and healthcare expenses. Sometimes the patient may neglect to provide sufficient information to a provider because they cannot remember the information due to mental disorders, such as dementia or Alzheimer's disease. Other times, inadequate communication results from patients' mistrust in the medical community, resulting in a deliberate withholding of information.² No matter the reason, underaccommodation is present in patient-provider communication and can be very harmful, resulting in undesirable outcomes.

The other, equally as harmful, communication issue that geriatric patients face is overaccommodation. This refers to the phenomenon of healthcare practitioners talking down or patronizing a patient due to a belief that the patient has limited capabilities.² Overaccommodation can be observed as changes to an individual's speech beyond what is considered an optimal level. This is particularly evident when talking to people who are perceived as having a specific handicap.⁴ In practice, doctors may communicate with patients with a hearing loss in a loud and oversimplified manner. This is an example of overaccommodation because the patient did not have altered mental status, but the provider over accommodated due to his preconceived notions of what the patient needed. After this conversation, the patient may feel disrespected.⁴ This interaction is "based on perceived needs rather than the actual needs of the patient."² These accommodations may be deemed appropriate with certain patients, however, they may be viewed by other patients as excessive and inappropriate.⁴

Overaccommodation includes both a provider's word choice and their tone of voice. Slower speech, higher pitches, fluctuations in emotional tone, and increased loudness are adjustments in conversation between older adults and providers that may be unnecessary.^{4,7} Changes in word choice that can be seen in overaccommodation include the use of diminutives, simplified grammar or vocabulary, and collective pronouns.^{7,8} The idea of overaccommodation may be difficult to fully grasp so the following examples demonstrate overaccommodation in word choice between a healthcare provider and an elderly patient in practice:

"Good morning *big guy*. Are we ready for *our* bath?"⁷

"Hi, *sweetie*. It's time for *our* exercise today. *Let's* get ready to walk down the hall."⁷

In these examples, the speaker belittles the patient by saying "big guy" or "sweetie" and the speaker uses collective

pronouns like "our" and "let's". While these phrases may be used with good intentions, they can be misinterpreted by the patient as condescending. This can leave the patient feeling as though the provider has little respect for her/him.⁸ Especially if the older adult lives in a nursing home or assisted living area, communication like this can manifest itself as decreased self-worth and lower self-esteem.^{7,8} The patient can become more dependent, isolated, and have decreases in cognitive and physical status which further results in more overaccommodation from healthcare providers.^{7,8} In a community or general healthcare setting, overaccommodation can be perceived by patients as both inappropriate and rude, but it has less of an impact on their decline in function.^{5,8} Whether in an institution or other setting, overaccommodation can be detrimental to a patient's health care.

Very often, overaccommodation is not intentional and it is done because the providers care for the patient and are concerned about their well-being. However, overaccommodation is seen as controlling rather than helpful.⁸ Overaccommodation is hurtful to the patient-provider relationship no matter what setting. Whether it demonstrates disrespect or it results in a decline in function depends on the amount of exposure the patient has to the overaccommodation. It has been suggested that use of overaccommodation towards elderly patients has a cumulative effect and may result in a faster decline with more exposure to it.⁶ If a patient lives in a nursing home and overaccommodation is all they experience on a daily basis, they will likely decline much faster and the effects will be much more prominent.^{7,8} This just further demonstrates how crucial geriatric communication is in practice.

Over and underaccommodation plagues many settings in the healthcare system. As our population continues to age, these issues become more widespread and problematic. Increasing providers' awareness of over and underaccommodation will help correct their speech patterns to better meet a patient's needs.² Understanding and recognizing these accommodation models will not only enhance communication between providers and patients, but it will improve health outcomes.⁷

I have witnessed how frustrating accommodation errors can be for an older adult and I hope to be a part of the change. I have prepared myself to be able to speak to geriatric patients respectfully and make them feel comfortable once I am a practicing pharmacist. After talking with my grandma and her friends extensively about this topic, I have armed myself with plenty of information and advice on how to communicate with geriatric patients. A question I had never asked my grandma until writing this paper was if she had ever told anyone her dislike for over or underaccommodation. She simply said, "We may be bothered by it, but we were all raised in an era where we just ignore it." My hope is that knowing and understanding some basic principles of accommodation theories will better prepare healthcare practitioners and other individuals to communicate effectively with the older members of our society. Communication between patients and providers is fundamental to safe and effective health care practices. Although this is just the first step to improving communication, by recognizing and correcting

over and underaccommodation, providers and elderly patients will be able to work together towards a happier and healthier life.

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