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COMMUNICATION WITHIN THE COMPREHENSIVE GERIATRIC ASSESSMENT

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The comprehensive geriatric assessment (CGA) forms a cornerstone of geriatric care; the process is designed to assess the complex interaction of biological, psychological, and social challenges often faced by elder patients (e.g., Extermann, 2003). Using a narrative case study of a patient undergoing a CGA by members of an interdisciplinary geriatric oncology team, I explore some of the communication challenges and opportunities for healthcare providers caring for geriatric patients. My goal in offering readers narratives of geriatric patient-healthcare provider communication—rather than only analysis of those interactions—is to complement typical analysis of research findings with an opportunity to do what Frank (1995) called “thinking with” a story, that is, to bear witness to someone’s experience and empathize with it. To contextualize the communication issues exemplified in the case study, I begin by defining the CGA, exploring its use by geriatric healthcare teams, providing a brief overview of common communication issues in the geriatric patient population, and introducing the project from which this case study is drawn.

DEFINING THE COMPREHENSIVE GERIATRIC ASSESSMENT

The comprehensive geriatric assessment (CGA) is “a multidisciplinary diagnostic process intended to determine a frail elderly person’s medical, psychosocial, and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up” (Rubenstein, Stuck, Siu, & Wieland, 1991, p. 8S). The CGA process involves the use of a variety of “standardized instruments to evaluate aspects of patient functioning, impairments, and social supports” (Wieland & Hirth, 2003, p. 455). The team I studied utilized the Geriatric Depression Scale, the Activities of Daily Living (e.g., bathing oneself), the Independent Activities of Daily Living (e.g., housekeeping), the Mini-Mental State Examination (detects cognitive processing and memory deficits), and Body Mass Index score (to screen for malnutrition). Such assessment and coordination of treatment and services is especially important for older patients because this population of patients is more likely than others to have both multiple health needs and complex interactions of medical, psychosocial, and material circumstances (Satin, 1994; Siegel, 1994; Stahelski & Tsukuda, 1990). CGAs help detect unknown or suboptimally treated medical conditions in geriatric oncology patients (Extermann, 2003), and they also uncover relevant information that affects patient care, such as the patients’ financial resources and insurance coverage, their preferences for types of care in various situations, and the availability (or lack) of family members to provide home care (Elon, Phillips, Loomer, Denman, & Woods, 2000). Ideally, CGA also improves diagnostic accuracy and the development of appropriate, comprehensive treatment plans for patients (Mosqueda & Burnight, 2000).

HEALTHCARE TEAM AND THE CGA PROCESS

The use of an interdisciplinary or multidisciplinary healthcare team to conduct the CGA is standard practice in geriatric settings (Osterweil, Brummel-Smith, & Beck, 2000; Wieland & Hirth, 2003). Geriatric teams are designed to meet the needs of elderly patients; they may be multi-, inter-, or transdisciplinary in organization.¹ Geriatric evaluation teams are extremely effective at assessment and intervention (Applegate, Miller, Graney et al., 1990; McCormick, Inui, & Roter 1996) and correlate positively with a range of desirable outcomes, such as increased patient satisfaction (Trella, 1993); better coordination of patient care (McHugh et al., 1996); improved functioning in “Activities of Daily Living” (Rubenstein, Josephson, Wieland, English et al., 1984); fewer nursing home admissions following hospitalization (Wieland, Kramer, Waite, & Rubinstein,

1996; Zimmer, Groth-Junker, & McClusker, 1985); decreased mortality one year after discharge (Langhorne, Williams, Gilchrist, & Howie, 1993); and decreased prescribing of psychotropic drugs among nursing home residents (Schmidt, Claesson, Westerholm, Nilsson, & Svarstad, 1998). Members of different disciplines work together to provide geriatric care, and programs such as the one I studied were set up to make the illness experience as positive as possible for these patients by more effectively addressing their health and illness management needs (Stahelski & Tsukuda, 1990). Teams commonly include professionals from medicine, nursing, social work, and dietary, but may draw from a wide range of other disciplines, including pharmacy, psychiatry, physical therapy, and occupational therapy.

Teams have specific communication challenges and opportunities as they communicate with patients. The interdisciplinary team-patient relationship differs from the dyadic physician-older patient relationship both positively and negatively. Team care may provide more autonomy for patients and a less intense one-on-one relationship, which some older people seem to prefer (Siegel, 1994). With a team, patients are able to direct concerns to staff members with whom they are more comfortable, and they may feel less dependent on a single healthcare provider. On the other hand, patients may feel uncertainty about which team member to contact for a particular issue, repetition of history and multiple visits may be necessary, and patients may give conflicting information to different team members, causing confusion (Siegel, 1994). Communication between patients and team members becomes exponentially more complex as the team members communicate with each other before, after, and sometimes during their interactions with patients (Ellingson, 2003). Collaboration among team members can influence subsequent encounters by preparing a team member ahead of time to deal with an issue such as a patient's difficult affect or hearing loss. More problematically, such collaboration also can involve sharing negative impressions of a patient before a team has encountered him or her, potentially adversely affecting the quality of the subsequent interaction. Research has focused on physician-patient communication, despite the fact that older patients are likely to interact with a wide range of healthcare providers (Haug, 1988). Clearly, communication among team members as they care for patients is much more complex than physician-patient communication, and warrants further study.

A NARRATIVE CASE STUDY

The case study is drawn from an ethnography I conducted of a geriatric oncology team and its patients at a cancer center in the southeast United States (Ellingson, 2005). The Interdisciplinary Oncology Program for Older Adults (IOPOA)² team consisted of two oncologists (one of whom was the director of

the program), a nurse practitioner, two registered nurses, a registered dietitian, a licensed clinical social worker, and a clinical pharmacist. The team provided a comprehensive geriatric assessment and treatment plan to each new patient over the age of 70 who came for an initial visit to Southeast Regional Cancer Center for treatment or for a second opinion. Each new patient was screened for depression, cognitive processing and memory deficits, risk of polypharmacy and drug interactions, physical impairment or disability, and malnutrition. In addition, the team conducted a thorough medical history, psychosocial evaluation, and physical exam. These assessments resulted in direct interventions into patients' care by team members (e.g., arranging for home healthcare services, changing patient diet). In addition, they influenced the treatment plans that the oncologists developed. I conducted participation observation with the IOPOA team for over 2 years, as part of a study of team communication in the "backstage" areas of the clinic (Ellingson, 2003, 2005).

In this chapter, I use brief narratives of one patient's experience with the IOPOA CGA process to illustrate some of the many communication issues involved in geriatric oncology care. These narratives are based on one of the nine audio-recordings of patients meeting with each of the team members that I produced and transcribed to supplement my extensive fieldnotes. The narratives in this chapter consist of excerpts of the actual communication among the patient, his wife, and the members of the IOPOA team. However, as the tape yielded 41 single-spaced pages of transcript, the interactions have been significantly condensed and then edited for clarity. I introduce the patient, Mr. Keith, and his wife as the process of the CGA is explained them by one of the registered nurses in the IOPOA.

* * *

Beth Young knocked on the examination room door and opened it without waiting for a response. "Hi!" she said as she entered the room.

Mr. Keith looked up from the issue of *Time* magazine he had been skimming, his large silver glasses shining in the bright fluorescent light. "How do you do?" he asked politely.

Smiling, Beth explained, "I'm Beth. I'm Dr. Armani's nurse."

"OK," said Mr. Keith, nodding. Like most of the patients at the IOPOA clinic, Mr. Keith and his wife were dressed in the casual cotton clothes popular among the area's many retirees. His navy shorts and golf shirt and Mrs. Keith's white pedal pushers and periwinkle blue knit top looked crisp and fresh despite the oppressive heat and humidity outdoors.

"I don't know if they explained to you when you had the appointment made for you that Dr. Armani uses the team approach for patients' first visit," began Beth. "There's the nurse practitioner, the pharmacist,

the dietitian, and the social worker. We all meet with you first, gather the information and then pass it on to Dr. Armani, who will come in to see you at the very end. And I think that the nurse practitioner will be first to see you today. We'll probably get finished when it's time to go to lunch." Beth looked at Mr. Keith, and he nodded his understanding. "You'll see me every visit, and I'll be answering your phone calls and problems, any questions that may occur—like a case manager. So I'll give you my card at the end of the visit today. OK?"

"Yeah, all right," said Mr. Keith, turning to his wife.

"Yes," echoed Mrs. Keith, nodding, her small, tight smile and furrowed brow revealing her anxiety. She snapped the clasp open on her purse and rooted through the contents until she found a tissue.

Beth nodded and moved toward the door of the small room. "See you later," she called over her shoulder as she turned the knob.

"Bye," called Mr. Keith. His wife elbowed him in the side and gestured toward the white plastic grocery bag on his lap. "But what about this medicine?" he asked Beth.

Beth looked back at the patient. "Who? Oh, the pharmacist. You can give it to her."

"Oh, the pharmacist. OK," said Mr. Keith.

Mrs. Keith shook her head. "I forgot about that," she said nervously. Her husband reached over and patted her hand, silently offering comfort.

* * *

COMMON ISSUES IN GERIATRIC PATIENT— HEALTHCARE PROVIDER COMMUNICATION

Research on communication between elder patients and their physicians documents a number of barriers to effective communication. Ageism is a form of discrimination against old people that plays a significant role in healthcare provider-older patient interactions (Hummert & Nussbaum, 2001). Many physicians' biases against older people affect their communication and treatment decisions (Adelman, Greene, Charon, & Friedmann, 1990; Beisecker, 1996; Haug, 1988, 1996; McCormick et al., 1996). However, when communication between older patients and healthcare providers is poor, it may be due to mutual reinforcement of stereotypes of the aged in their interactions, rather than solely due to pre-existing ageist attitudes on the part of the healthcare provider (Ryan, Meredith, &

Maclean, 1995; see also Nussbaum & Fowler, this volume, for a discussion of communication accommodation theory). Other factors such as race and gender intersect with age and affect physicians' treatment decisions (Beisecker, 1996; Clark, Potter, & McKinlay, 1990; McCormick et al., 1996). Ethnic differences, language differences, and differences in religious and cultural beliefs also make provider-patient relationships more problematic (Haug, 1996; Haug & Ory, 1987; Ryan et al., 1995). Class is also a crucial factor in physician-patient communication. Physicians tend to give less time and less complete information to people of lower socioeconomic classes (Pendleton & Bochner, 1980); poor people, including many elderly, are more likely to be devalued and receive poorer care than those in higher socioeconomic classes with private insurance (Jackson & George, 1998). Older patients also are more likely than younger patients to have impairments in hearing, vision, cognition, and function that affect communication with healthcare providers (Ryan et al., 1995). Older patients often are reluctant to express complaints, confusion, disappointment, or misunderstandings with physicians (Breemhaar, Visser, & Kleijnen, 1990). Although it is impossible to do justice to all the communication issues that may arise in communication between healthcare providers and geriatric patients, I explore several issues that are integral to the CGA process: coordinating treatment for multiple serious illnesses; encouraging patient adherence (compliance); understanding patients' psychosocial well being; the role of patients' companions (e.g., adult children, spouse) in interactions between patients and healthcare providers; and communication of the treatment plan.

Communication and Coordination of Care

A person's chances of developing multiple chronic illnesses, impairments, and functional deficits increases dramatically with age (Mosqueda & Burnight, 2000). Older people are more likely than younger groups to have co-morbidities or chronic and acute conditions, such as diabetes, heart disease, or emphysema, that must be managed while organizing treatment for the current complaint, a cancer diagnosis in the case of IOPOA patients (Satin, 1994; Siegel, 1994). Yet, older patients are likely to have fragmented care, seeing a different specialist for each chronic or acute condition (Beisecker, 1996). Increased specialization contributes to the need for collaboration between experts in different areas of knowledge and greatly increasing the need for coordination of care and treatment (Cooley, 1994; Satin, 1994; Stahelski & Tsukuda, 1992). Thus, an abundance of complex information must be sorted through and discussed to provide an appropriate treatment plan. Mr. Keith's need for coordination of care for his co-morbidities is evident in the following excerpt of his interaction with the IOPOA nurse practitioner.

* * *

"Hey there Mr. Keith," called Elaine cheerfully as she used her shoulder to push open the examination room door. In her arms, she carried a large pile of paperwork that documented the ins and outs of Mr. Keith's medical history.

Smiling, Mr. Keith shook her hand and asked, "How do you do?"

"Good, nice to meet you. My name is Elaine Lyndon," she said, plopping the pile of paper on the long counter to her right. Turning to her patient's companion, Elaine offered her hand and asked, "And you are?"

"Mrs. Keith, his wife," she explained, nodding slightly.

Elaine pulled a stool up to the counter so she could use it as a writing surface. "Oh! I'm glad you came. And I'm the nurse practitioner." The couple nodded. "Good. So, did you want a second opinion or are you looking for a physician or ...?" Elaine let the question trail off.

Mr. Keith shrugged. "Both, I guess. We don't know."

"Are you currently with somebody?"

"Dr. Lerner."

Elaine nodded and made a note on the patient chart. "All right, so will you tell me your history of what happened? I just want to hear it from you."

"Well, last December, early December, I complained of a back ache," began Mr. Keith. "And I went to my family physician, Dr. Paterson. And, um, they gave me some tests. And they said that there was arthritis. Mild arthritis?" he asked, giving his wife a questioning glance. At her nod, he continued, "Yeah, mild arthritis, and I still complained. Stomach started to bother me. So he sent me for more tests—x-rays of the back, kidney tests. And then they sent me for ah—what was that?" Mr. Keith turned to his wife.

"Endoscopy," said Mrs. Keith, naming the procedure in which a tube containing a tiny camera is passed down the patient's throat, allowing a physician to view the upper regions of a patient's digestive tract.

Nodding, Mr. Keith continued, "Endoscopy. And he decided to have my gall bladder removed and then when they did that, and they found something in my liver. Then I had a biopsy done, and the biopsy said that I had cancer of the liver." Elaine looked up from her notes and nodded at her patient, and he continued, "But then they said, 'you don't usually see cancer of the liver, something else—got to start some other place.' So they took scans of the brain, the lungs—"

Mrs. Keith interjected, "And everything looked good."

"And that's all they found so far. The pancreas and the liver," concluded Mr. Keith.

Elaine made more notes before looking up. "OK. Very good. And what other kind of medical problems did you have?"

"Oh, I had a bypass. A five-bypass operation. Then he gave me Coumadin [blood thinner], then I left. Then there was a problem with my kidney and the chemo."

"Which kidney?" asked Elaine, her pen poised over her papers.

"Right."

"OK," said Elaine. "Other issues?"

Mr. Keith paused for a moment, then said, "High blood pressure. Extremely high blood pressure. So then they put me on another medication for that. And, ah, that's about it."

Mrs. Keith laid her hand on her husband's leg to get his attention and prompted him softly, "Diabetic."

"Oh!" exclaimed Mr. Keith. "I'm diabetic too."

Elaine made yet another note and asked, "On insulin?" Mr. Keith nodded, and then Elaine joked, "This is a test of your memory!"

Mr. Keith laughed. "Oh boy—I had a tetanus shot in 1945." Elaine and Mr. Keith chuckled for a moment, but Mrs. Keith managed only a small smile. They continued to discuss his blood pressure and cholesterol medications and a recent blood clot in his leg, and then ruled out a history of a series of conditions such as tuberculosis and ulcers.

Shifting smoothly to the next topic, Elaine asked, "Any problem with the carotid arteries?"

"Yes, when I went back to Dr. McAllister. And he was going to do my carotids and an angiogram. But then this came up, and they said it was more important—the cancer is top priority."

"Did he tell you how clogged they were?" inquired Elaine.

"Um, 80% something like that. I don't know."

Mr. Keith looked to his wife again, and she chimed in, "He said he couldn't be sure until they did the operation."

Elaine finished taking Mr. Keith's medical history and then chatted with him while she conducted his physical exam. "What kind of work did you use to do?" she asked.

"Well, thirty years of the phone company and ten years of General Electric company."

"All right," said Elaine. "Take off your shirt, please." As her patient complied, she asked, "So how long have you been in living in this area? When did you retire?"

Mr. Keith smiled, "Retired in '91. I've been coming down here a long time, but we've lived here four years."

After completing the exam, Elaine offered Mr. Keith a hand to help him down from the raised examination table. "All right! You can get yourself put back together there again. We'll go ahead and um get the next person in to see you. I'm probably the longest one. OK?"

"OK. Thanks a lot," said Mr. Keith as he buttoned his shirt. "Good meeting you."

"Nice meeting you both," said Elaine, hurrying out the door.

* * *

Obviously, Mr. Keith has a number of serious health issues, the treatment of which may need to be adjusted during the course of chemotherapy he is undergoing for liver cancer. At minimum, the IOPOA oncologist will need to consult with Mr. Keith's endocrinologist about his diabetes care and his cardiologist about the patient's heart disease. Although Mr. Keith's view of the situation—that the cancer has top priority—is valid, the other illnesses remain significant threats to Mr. Keith's well being and even to his life. Unfortunately, because none of these physicians are part of the same healthcare organization, maintaining open lines of communication among them is very difficult. Whereas most specialists concentrate on the particular illness for which they treat a given patient, the CGA process brings to light a holistic view of the patient's healthcare needs.

Communication and Patient Adherence/Compliance

Healthcare providers seek to encourage patients to adhere or comply with their prescribed medication regimens and other treatment plans. This task is made more difficult by the number of drugs taken by many elder patients. Polypharmacy—the prescription of an excessive number of drugs—is a significant risk for elders who are more likely than younger people to take multiple medications (Schmidt et al., 1998). Also, elders often are prescribed drugs by multiple healthcare providers who may not be aware of what else the patient is taking, placing patients at risk for potentially dangerous drug interactions (Reuben, 2000). Additionally, patients may take substantial doses of vitamins or herbal supplements, some of which can interfere with prescribed treatments and/or negatively affect other chronic or acute illnesses (Eisenberg et al., 2001). Because patients often are not supported by healthcare providers when they do report their use of complementary medicine (Gray et al., 1997), many patients become reluctant to talk about their use of such therapies (Eisenberg et al., 2001). Yet this is vital information that should be discussed.

* * *

Clinical pharmacist Susan Ford introduced herself to Mr. and Mrs. Keith, explained that she intended to review his medications with them, and questioned him about drug allergies. She continued, "OK. I'd like to start from the top of the medicines on the list you filled out." Mr. Keith nodded, and Susan asked, "The Percodan—how long have you been taking that?"

Mr. Keith thought for a moment. "Ah, I think February."

Susan noted his response and asked, "You're taking it five times a day?"

Shrugging, Mr. Keith explained, "Well, every four hours. I don't get up in the middle of the night and get it."

"You feel that is controlling your pain?" inquired Susan. "If you had to rate your pain from zero to ten with zero being nothing, and ten being the most excruciating pain you've ever had, where would your pain fall?"

"Zero," responded Mr. Keith quickly.

"Zero," repeated Susan. "When was the last time you took a pain pill?"

Mr. Keith chuckled. "Oh, about 20 minutes ago."

Smiling, Susan asked, "Do you find that they do well for a period of time? How long would that be?"

"I found that one wasn't enough. But I noticed just about the last couple of days or week, I took the two and I feel a lot better. My appetite is getting better and everything else."

"When the medication burns off, where would you say your pain rates?" asked Susan.

"Ah, I would say about three or four, somewhere around there. My stomach is mostly what bothers me."

Susan checked the list of medications. "OK, the Celebrex could be causing that."

Mr. Keith nodded. "I took that because of my back, I had mild arthritis, and it did help with my back pain."

"Are you taking the tablets with food, or on an empty stomach?"

Shaking his head, Mr. Keith said, "No, I never eat. The only thing I take with food really is the Coumadin [blood thinner]. Everything else, I just take it."

Susan looked thoughtful. "One of the problems with Celebrex—well with any of those anti-inflammatories—is that they can upset your stomach. So what I would suggest is to take it with food just to be on the safe side."

Mr. Keith paused for a moment and then nodded. "OK," he said.

Susan nodded, satisfied. "Good. Now, you're taking Coumadin, you said. How long have you been taking that?"

"Since March of '97. That I'll be on the rest of my life," added Mr. Keith.

Susan looked up from her notes and asked, "What did the doctor put you on it for?"

"Bypass," replied Mr. Keith.

"And when are you taking the Coumadin?"

"When I eat supper, I take it."

"You take it when you eat supper?" asked Susan, her voice reflecting surprise and disapproval. "You might not want to do that. Depending on the food you are eating, things like broccoli and greens interfere with the absorption of Coumadin. So the rule of thumb usually is that it is best to take it about an hour before you eat. That's always a good time."

"Yeah, OK," agreed Mr. Keith. He added, "Every two weeks I get a PT [test to determine how quickly blood clots]."

Susan nodded. "Good. You've got a sleeping pill listed here."

"Oh my sleeping pills. Oh yeah, I take them every night."

"How long have you been taking them?" asked Susan.

"Um, January," said Mr. Keith, looking again to his wife for confirmation. She nodded, and he continued, "Cause I was waking up every night, three or four times a night."

"And the medication is taking care of it?" asked Susan.

Mr. Keith and his wife both nodded. "I don't even wake up any more," he said.

Susan continued to query Mr. Keith on his medications and use of vitamin supplements, then closed the interview by offering to answer any questions the Keiths had.

* * *

Many times patient nonadherence to prescribed medication regimens is the result of misunderstandings or a lack of clear instructions, rather than willful disregard of healthcare provider's instructions (Hammond & Lambert, 1994). Sometimes clarification is all that is needed; other times patients disagree with instructions they have received, and healthcare providers attempt to influence patients' beliefs and attitudes to encourage change. In my study of the IOPOA team (Ellingson, 2003), I found that team members strategized extensively out of patients' presence about how to persuade patients to adopt or discontinue specific behaviors. Team members sought each other out to request that their col-

leagues reinforce pieces of information or advice to patients. For example, one common issue that the pharmacist and dietitian conspired to persuade patients about is the danger involved with excessive consumption (>400 IUs/day) of supplements of fat-soluble vitamins, such as vitamin E, which are toxic at high levels. They would often "double-team" patients who were taking large doses of vitamin supplements in the hope that repeating the message would increase patients' likelihood of changing their consumption to a safe level. Despite its potential for improving patient health outcomes and the goodwill with which it was undertaken, such strategic communication among team members increased healthcare providers' power over patients, undermining patient autonomy and excluding them from vital conversations that directly concerned them. More consideration of the ethics of this type of communication is needed to help articulate better approaches to balancing respect for patients with the seriousness of the health threat posed by some forms of nonadherence.

Communicating about Psychosocial Well Being

The CGA is designed specifically to address patients' psychosocial well being as well as their biomedical disorders (Extermann, 2003). Researchers have found that geriatric provider-patient communication consistently involves the marginalization of psychosocial information. As with the general population, the content of communication between physicians and older patients is largely medical, with little time given to psychosocial issues (Adelman Greene, Charon, & Friedmark, 1992). Mishler (1984) argued that physicians are more comfortable with and attuned to the "voice of medicine" and often exclude or minimize the "voice of the lifeworld," that is, the context of the patient's life experiences. Yet attention to this lifeworld is critical to the care of the older patient because of the unique biopsychosocial, financial, and relational factors that often confront people in their later years (Elon et al., 2000). Physicians tend to be uncomfortable addressing intimate topics raised by older patients, particularly negative emotions such as embarrassment, worry, and fear, and tend to ignore intimate topics or refuse to pursue them with questions (Greene, Adelman, Rizzo, & Friedmann, 1994).

* * *

"Hi! I'm next. I'm Joyce, the social worker," said Joyce Fitzgerald, reaching to shake Mr. Keith's hand. "Are you Mrs. Keith?" she asked as she shook the woman's hand.

Mrs. Keith nodded. "Yes, I am."

Joyce pulled the rolling stool out from the corner and seated herself so that she was close to the couple. "What I'm going to do," she began in her soft Southern voice, "is to ask you a few questions, so we know a lit-

tle bit more about you, OK? Then I'll give you a couple tests. Tell me what the situation is, do you have children, grandchildren?"

Mr. Keith smiled. "I have five children and a lot of grandchildren. I have one daughter that works for hospice and I have one daughter who is a pool inspector nearby."

Mrs. Keith added, "We have another daughter living with us right now; she just moved in from Texas. It's temporary; she's looking for a place. Her kids are six and four. Having them stay with us is fun for me." She gave her husband a dubious look. "I don't know about him."

Joyce smiled warmly and asked, "Can you believe that you did all that at one time?"

Mr. Keith laughed. "The five kids, yeah, they were hers." He touched his wife's hand gently. "I always was a kid too." Mrs. Keith smiled indulgently, for a brief moment looking happier than she had since the appointment had begun.

Joyce skimmed through the financial information on the form. "And you're on pension. OK. And you get prescription coverage, and ah, you've got Medicare. You see um, Dr. Lerner." Mr. Keith nodded steadily throughout, providing confirmation of the information. "OK," Joyce continued, "What have you had done as far as treatment?"

"Two chemotherapies I've had," explained Mr. Keith.

Joyce looked up from her notes and asked, "And how did you do with it?"

"I thought I did good," said Mr. Keith. Mrs. Keith shook her head. "She says no, no," he added with a chuckle. "I thought, well, I slept the first day, and after that I didn't eat; otherwise I thought I was very good, outside of not eating."

Joyce turned to Mrs. Keith and smiled encouragingly. "OK. Why do you feel like he didn't do very good?"

Mrs. Keith leaned forward and looked intently into Joyce's eyes. "Well, because he slept the first day, and I know that the next several days he had no appetite *whatsoever*."

"OK," said Joyce, nodding. "How do you feel today?" she asked, turning back to Mr. Keith. "On a scale from 1-10, what would you say?"

Mr. Keith thought for a moment and then said, "Oh, I would say seven or eight."

Joyce nodded. "OK. How about your spirits, on a scale from one to ten?"

Looking thoughtful, Mr. Keith said, "My spirits? I don't mean to disagree, but they're not so good."

"Have you had to chip in more to help out, with other people staying with you at home?" she asked casually.

Mr. Keith shrugged. "Yes, but, well, you're talking about *that*. I'm talking about *cancer*. I accepted that there's no cure. The doctor told me there's no cure." Gesturing to his wife, he added, "And she says, 'you got to give him the gung-ho stuff' and all that, you know. My attitude should be different, she says."

Mrs. Keith nodded. "He's kind of got his nose up against the wall."

"I do," agreed Mr. Keith. "I do have a negative attitude."

Joyce made a note on her paper work and asked, "Negative in terms of what?"

"There's no cure. I know there's no cure," stated Mr. Keith.

Joyce nodded. "The doctor told you that?" she asked.

"Yes. The doctor told me that," said Mr. Keith quietly.

Mrs. Keith added, "It's probably not going to go away; but at least the treatment is going to buy him time and, you know, be some *quality* time."

"When you go into the treatment, do you feel like it will buy you time?" Joyce asked.

Mr. Keith shook his head. "I don't know. I'm a great movie buff. And I know that Steve McQueen had cancer of the pancreas and it went to the grave. Michael Landon's another one. Who's the other one? James Stewart. Donna Reed, she's another."

"So when you're having chemo, you're not very hopeful," said Joyce. Mr. Keith shook his head. "Besides how you feel about your chances, how do you feel emotionally, at the moment?"

"At the moment, I take one day at a time. Just like an alcoholic—take one day at a time. We all have to go sometime. We all got to die," Mr. Keith said, shrugging. "So, it's my time to die," he added simply.

"You thought you had a good life?" probed Joyce gently.

Mr. Keith nodded. "Yes, I had a good life. I just feel I ain't going to be around much longer."

"And he's not very verbal about that," added Mrs. Keith.

"I'm not verbal," Mr. Keith agreed. "She had to call all the kids and everything else, and say that I had cancer. 'Cause I couldn't do it."

Joyce turned to Mrs. Keith. "A lot fell on you," she said supportively. Mrs. Keith nodded.

"She's had the hard part," said Mr. Keith.

"Well, I wouldn't say that," Mrs. Keith replied.

"I'd say both of you have a pretty tough part to play here," said Joyce. "I'm going to have you fill out some questions here along the these lines. OK?" Joyce handed him a copy of the Geriatric Depression

Scale, and after he completed it, asked him the series of questions included within the Mini-Mental State exam to test for memory or cognitive processing deficits. When they are finished, Joyce offered the couple her psychosocial assessment of Mr. Keith. "Basically, your memory is positively intact. And as far as the depression scale, I circled the items that would be of concern. That means you are at risk for depression. If you have more than five of these, we're concerned. You have four, so I'd keep an eye on it. Especially since you're not a person that would probably be really open about your concerns." Joyce shifted her gaze back and forth between her patient and his wife.

Looking worried, Mrs. Keith interjected, "The first thing that he verbalized was that he was worried about me and the family, not himself."

Joyce nodded and turned to Mr. Keith. "Well if you feel that way, then your wife needs to know."

"Yeah," said Mr. Keith.

Joyce leaned closer to him. "You've got to make sure you've got everything worked out, that you communicate with each other about how you're feeling." Mr. Keith nodded. Joyce gathered her materials and stood. "I'm going to give you my card, in case you have questions later."

"OK. Thank you very much," said Mrs. Keith.

Joyce smiled at both of them. "It was a pleasure meeting you."

Mr. Keith nodded. "Yes, it was," he said to Joyce as she left the room. "Bye."

* * *

The CGA brings professionals from multiple disciplines to care for patients, relieving physicians from the necessity of addressing every aspect of patients' lives. Although all team members may address psychosocial issues, the social worker's set tasks (e.g., administering the Geriatric Depression Scale) most directly relate to patients' emotional coping, family and social support, and financial resources. In Mr. Keith's case, he had family support and sufficient financial resources, but he was clearly struggling with the implications of his diagnosis, which he understood as equivalent to a death sentence.

Communication with Patients' Companions

Reviews of health communication research conclude that patients' companions play vital roles in patient-healthcare provider interactions (Haug, 1996; Thompson, 1994). The presence of a companion is normative among oncology patients (Beisecker & Moore, 1994), and older patients are more likely to bring a caregiver or companion than are younger patients (Adelman, Greene, &

Charon, 1987; Beisecker, 1996). In a geriatric oncology setting, where the patients are both old and often quite sick, the vast majority of patients bring a friend or relative of some sort with them (Beisecker & Moore, 1994). The presence of a third person has significant impact on the interaction between patient and healthcare provider. The companion may inhibit or enhance a patient-physician encounter (or do both) and is likely to play multiple roles during a single visit (Adelman et al., 1987; Beisecker, 1989; Beisecker & Moore, 1994).

The role of companions in provider-patient interactions is particularly relevant in geriatric settings. In general, companions are most likely to be spouses, parents, siblings, and adult children (Beisecker & Moore, 1997). Married patients are generally accompanied by spouses (78%) (Labrecque et al., 1991). Elderly patients generally bring family members (Beisecker, 1989), most likely daughters or wives (Haug, 1988, 1996). More than one companion may accompany a patient, which makes the interaction with healthcare providers exponentially more complex (Glasser, Rubin, & Dickover, 1989; Hasselkus, 1994). Greene, Majerovitz, Adelman, and Rizzo (1994) found that triadic encounters involving a companion were more likely than dyadic encounters to involve older patients raising fewer topics, being less assertive and expressive, engaging in less joint decision making with physicians, sharing less laughter with physicians, and even frequent exclusion of the patient from the conversation. Coalitions may form in the physician-patient-caregiver encounter, and older patients may be ignored as physicians and caregivers make decisions (Coe & Prendergast, 1985; Hasselkus, 1994; Haug, 1988; Rosow, 1981). Presence of a companion also may trigger assumptions of patient incapacity (Hasselkus, 1994). Patient permission is usually not directly sought for the companion's presence to continue throughout the interaction with the physician, and this raises ethical issues about privacy and patients' rights (Adelman et al., 1987).

* * *

After introducing herself and shaking hands with Mr. and Mrs. Keith, Ashley Breton, a registered dietitian, began her nutritional assessment. "I have several questions for you and then I'll answer any questions you might have, and take two measurements. OK?" At their nods, Ashley continued, "Tell me, what would you say would be your usual weight?"

Mr. Keith replied, "About one seventy-eight"

Ashley nodded. "One seventy-eight, OK. And your paperwork said that you lost twenty-five pounds over the last three months, is that right?"

"Yes, couple of months," he agreed.

"At this point, do you think your weight is stable, or that you're losing weight?" inquired Ashley.

"Oh I just gained two pounds," said Mr. Keith, smiling. "Either the chemo wore off or the Megace [appetite stimulant] kicked in. I don't know, but I'm eating pretty good last couple of days."

Ashley made a note on her assessment form. "Good. When did you start taking the Megace?"

"Couple days ago."

"OK," she said. "Let me tell you what I see in real life experience with the Megace. Usually it takes about two weeks, and then there is a difference. I'm glad you're seeing some improvement already. Could be related to not having the chemotherapy recently as well."

Mr. Keith nodded agreeably. "Like I said, it could be the chemo wore off. I haven't had chemo for two weeks."

"So the important thing is, at this point, your appetite is pretty good. Any other problems with your chemo, any side effects?"

"Ah no," said Mr. Keith. "Except that I was sleepy the day I got it, and for a couple days my appetite was bad. I didn't feel like eating at all."

"No problems with nausea or vomiting?" asked Ashley.

Mr. Keith shook his head. "No. I was told to take the [anti-nausea] pills no matter what, because they say the chemo can make you really nauseous. So I did, and I didn't have any problem with it."

Ashley and Mr. Keith discussed the need for him to drink more fluids to help his body cope with the effects of the chemotherapy, and his difficulty in doing so. "Well any kind of fluids—as long as they don't have caffeine in them—work towards keeping you regular and hydrated. So milk or juice also count as fluid, and they have calories too, which will help you maintain your weight. So you kind of kill two birds with one stone," explained Ashley patiently.

Mrs. Keith had been listening silently but with careful attention to the discussion of her husband's food and fluid intake. "I put a bit of food in front of him a few times a day," she offered. "Since he doesn't think to eat."

Ashley smiled warmly. "That's very good." She glanced at the form the Keiths had completed that listed what he had eaten over the course of a day. "It's hard, because when you don't have an appetite you could go all day without eating if the food is not in front of you. So that's one of the first things we recommend." She smiled encouragingly at Mrs. Keith.

Mrs. Keith nodded vigorously. "That's a very good recommendation. Because you need to eat," she said, touching Mr. Keith's arm for emphasis. He nodded. Mrs. Keith continued, "Actually he has been drinking whole milk lately, because my daughter is staying with us and has kids. So we buy whole milk."

"OK, good," said Ashley. "Little things like that would help and add calories that you don't even think about. And eating more often helps trigger your hunger. That will increase the amount of calories you eat, because it looks like the portions that you're eating are fairly small."

Mrs. Keith pointed to the paper Ashley held and added, "He was eating better the day that we did that. That was a *good* day."

"OK," said Ashley. "Well, keep trying to do this and hopefully his appetite improves."

Mrs. Keith still looked concerned. "It doesn't bother him, but in fact, those first three days, he doesn't want to eat *anything*."

Ashley said encouragingly, "You're on the right track with the small frequent meals." Shifting gears a bit, Ashley asked, "Right now do you check your blood sugar at home?" They discussed the importance of close monitoring of his blood sugar level and of adjusting his insulin dosage to reflect his decreased food consumption. "Keep on with that blood sugar testing. Let's see, what other questions do I have?"

"I'm busy tomorrow night," joked Mr. Keith, chuckling.

Ashley laughed, "Ah, you're in for it now!" she teased. "So you're getting some kind of meat every day?"

Mrs. Keith shook her head and answered for her husband. "No, not a lot of meat. Mostly vegetables."

"Try to have some kind of protein with every meal. If you don't like meat, then there's scrambled eggs, cheese and crackers, a glass of milk, peanut butter. That's important to help refurbish your body. And then fluid wise, you need to drink more."

Mr. Keith nodded. "No, I don't drink a lot. Except when I was in the Navy," he added with a saucy smile. "Then we all were drinking."

"We don't want to see much of that kind of drinking either," said Ashley, wagging her finger in a mock scolding, a broad grin on her face.

"No, we don't," echoed Mrs. Keith, her voice serious but a smile tugging at her lips.

Ashley spent several more minutes with the Keiths, offering suggestions on how to maintain Mr. Keith's weight before she wished them well and informed them that the doctor would be with them shortly.

* * *

Companions appeared to play similar roles in interactions with interdisciplinary team members during the CGA as they did in physician-patient interactions. Companions' roles included memory aid, emotional support, transcriber, aid in decision making, companionship, elaboration, advocate for patient, and inter-

preter (Ellingson, 2002). As others have noted (e.g., Adelman et al., 1987), companions are likely to play multiple roles in a single interaction, and companion roles were found to shift over time within and across the interdisciplinary team interactions. Specific patterns of variability included: relatively passive companions who performed more active roles when the physician was present than with nonphysician team members; relatively active companions who performed more passive or submissive roles when the physician was present than with nonphysician team members; and relatively passive companions who performed more active roles only when particular topics (e.g., the perceived need for a sleeping pill) were raised, regardless of the discipline of the team member.

COMMUNICATING THE TREATMENT PLAN

Researchers have argued that even though information is gathered from and direct assistance given to patients by all interdisciplinary team members, the information and assessments gathered and formulated by other professionals also are part of and integral to the physician-patient interaction and affect satisfaction of both physician and patient (McCormick et al., 1996; Miller, Morley, Rubenstein, Pietruszka, & Strome, 1990). In particular, physicians depend on the data and opinions of the other team members in making treatment decisions for frail patients with serious co-morbidities, patients who have specified that they do not wish to undergo a specific type of treatment (usually chemotherapy), cases in which patients' wishes are in conflict with those of their family members, patients for whom all treatment options have been exhausted and who face end-of-life decisions, and other complex situations.

* * *

Dr. Armani burst into the treatment room, his voice booming as always. "Hello Mr. Keith! Mrs. Keith!" After shaking their hands, he pulled up a stool so that he was sitting very close to them. He continued, "I was born and raised in Italy and still have a strong accent after twenty years here. You let me know if you can't understand something, OK?" The Keiths nodded and smiled. "Thanks for coming and seeing us. I have been in touch with Dr. Lerner, and I agree with what he is doing to you right now. I think he did everything just as I would have. How long does he plan to treat you with the Gemzar [chemotherapy]?"

Mr. Keith hesitated. "Well, what I got was a couple of months. But, I've been in the hospital and then my blood count was too low too, so they haven't done the next one yet."

Dr. Armani nodded vigorously, "I think a couple of months is probably enough; you can repeat the CAT scan and see if there is an improvement. An important question is, where is this coming from? It does not look like the primary tumor of the liver, OK? It looks like it's coming from somewhere else. The radiologist report on your the CAT scan said it might be coming from the pancreas, but it could even come from the colon. And how do you tolerate the chemo?"

"Well I just get sleepy that day and the next day. And have no appetite afterwards for awhile," explained Mr. Keith.

Dr. Armani asked, "Have you had a colonoscopy?"

"The last one was in February," chimed in Mrs. Keith.

Dr. Armani nodded. "You have no problems with your stomach?" he asked.

Mr. Keith shrugged. "No digestive problems, but I have pains in my stomach."

"He also had an endoscopy," offered Mrs. Keith quietly.

"Well I think that is a reasonable way to proceed," began Dr. Armani. "I think we first need to present your case before the cancer center's tumor board. And I'm going to present it, get their report, and then get back with you and with a recommendation. I want *our* pathologist to review the slides of your tumor to make sure that the cancer is as they say. If what they say there is correct, we can proceed with treatment. If there are questions, then I certainly could recommend a different course of action." Dr. Armani reached out and patted Mr. Keith's arm comfortingly while looking intently into his eyes, as though to ascertain the level of Mr. Keith's comprehension.

Mr. Keith nodded slowly. "All right. Now if I wanted to have everything done here instead of by Dr. Lerner, after you appear before the tumor board and all that, is that OK?"

"We can do that. But right now I don't feel like I can make any more recommendations. If you want to come here after we hear from the tumor board, I would be very happy to see about your care." Mr. and Mrs. Keith turned to each other and nodded, looking pleased. Smiling, Dr. Armani continued, "And I should mention though, that I am often late!"

Mr. Keith chuckled. "A doctor late? Really?"

Dr. Armani stood and again shook hands with the Keiths. "Bye bye. Take care. Beth will be in to see you in a moment."

"So nice meeting you," replied Mr. Keith. "Bye."

Ideally, the CGA process leads to better and more complete diagnoses and more holistic treatment plans that address emotional coping, management of co-morbidities, resource management, and any other patients needs (e.g., Wieland & Hirth, 2003). The variety of healthcare providers makes it more likely that patients will have their needs addressed, but is not infallible, of course; patient problems can and do slip through the cracks. However, the CGA process does a great deal to widen the scope of assessment typically conducted by physicians and often is responsible for a holistic treatment plan and a range of favorable patient outcomes (e.g., Extermann, 2003).

CONCLUSION & FUTURE DIRECTIONS

As discussed in this chapter and exemplified by the narratives of Mr. Keith's experience, the CGA process is conducted via extensive communication among the interdisciplinary team members, their patient, and the patient's companion. Thus, communication barriers that inhibit effective communication can have profound impacts on a patient's diagnosis, treatment, and health. Some key aspects of communication explored in this chapter include: coordinating treatment for multiple serious illnesses; encouraging patient adherence/compliance; understanding patients' psychosocial well being; the role of patients' companions in interactions between patients and healthcare providers; and communication of the treatment plan. Two primary implications of this chapter for future research are the continued need for study of communication between geriatric patients and healthcare providers who are not physicians, particularly those who work within a team, and the need for consideration of the patients' goals within the CGA process.

First, research on geriatric patients remains physician-centered, despite the fact that geriatric patients regularly interact with a range of healthcare and social service providers (Ellingson, 2002; Haug, 1988). Studies of geriatric teams have either focused on correlations between team interventions and desired patient outcomes (Cooke, 1997; Cooley, 1994; Fagin, 1992) or, less frequently, on decision making in formal team meetings (Opie, 2000). Few have looked at how an entire team of healthcare professionals communicates with patients (Ellingson, 2005; Siegel, 1994). The case study here demonstrated the vital role of communication in the CGA process. To improve this process, we need to better understand communication between geriatric patients and the healthcare professionals who represent a range of disciplines.

A second implication is that despite the comprehensive, biopsychosocial assessment yielded by the CGA, the control over the agenda remained firmly within the purview of the healthcare providers. Although the team's intentions were undoubtedly benevolent and informed by expertise, the process still cen-

tered on their beliefs and practices; the CGA is not patient-centered. That is, the patient's agenda or goals for the visit are not primary, or even necessarily noted (Vanderford, Jenks, & Sharf, 1997). A sincere effort was made to address the patients' concerns within the highly structured assessment process, but the structure of the process was rigidly maintained. Research on geriatric patients shows that physicians remain very much in control of encounters with older patients, raising more than two thirds of topics (Adelman et al., 1992). Older patients often appear to be more passive in interactions with physicians (Beisecker, 1996), often allowing physicians to make decisions without their active involvement (Beisecker, 1988, 1996; Owen & Batchelor, 1996). This may be a cohort effect that will change as increasingly educated people age and join the ranks of the elderly and socialization of patients to accept physician authority changes (Haug, 1996). In the meanwhile, despite the advantages of the CGA over assessment by only a physician, the control of the encounter has not shifted to empower the patient. Some scholars of teamwork have criticized the marginalization of patients' and family members' perspective within healthcare teams (Opie, 1998). Future work must consider the ethical dimensions of the significant power exerted by team members over patients (Ellingson, 2005), and work toward enhancing patients' opportunities to state their goals and have them met.

DISCUSSION QUESTIONS

1. What are the advantages of the comprehensive geriatric assessment process over a typical assessment by a physician?
2. How do you think the comprehensive geriatric assessment would be different if the patients were not accompanied by a spouse, adult child, or other companion? Have you ever brought a friend or relative with you to see a physician or other healthcare provider? How do you think it shaped your communication with him or her?
3. Comprehensive geriatric assessment is geared toward the needs of elderly patients. What other patients do you think would benefit significantly from comprehensive assessment? Why?
4. This chapter provided a narrative case study of a real patient to illustrate several communication topics. What did you gain from reading narratives about the patient that you would not have received from a summary or description of the patient? How does this affect your ability to empathize with the patient's experience?

ENDNOTES

1. Healthcare teamwork is generally conceptualized as exiting along a continuum of collaboration, with multidisciplinary team members (e.g., social worker, dietitian) engaging in parallel work on behalf of a patient, through interdisciplinary teams who engage in formal and informal information sharing and jointly develop plans across disciplines, to transdisciplinary teams that have highly flexible roles and permeable boundaries that transcend disciplinary distinctions (Opie, 2000).
2. The names of the cancer center and geriatric program, along with those of the staff and patients, are pseudonyms intended to protect research participants' privacy.

REFERENCES

- Adelman, R. D., Greene, M. G., & Charon, R. (1987). The physician-elderly patient-companion triad in the medical encounter: The development of a conceptual framework and research agenda. *The Gerontologist*, 27, 729-734.
- Adelman, R. D., Greene, M. G., Charon, R., & Friedmann, E. (1990). Issues in the physician-geriatric patient relationship. In H. Giles, N. Coupland, & J. M. Wiemann (Eds.), *Communication, health, and the elderly* (pp. 126-134). London: Manchester University Press.
- Adelman, R. D., Greene, M. G., Charon, R., & Friedmann, E. (1992). The content of physician and elderly patient interaction in the primary care encounter. *Communication Research*, 19, 370-380.
- Applegate, W. B., Miller, S. T., Graney, M. J. et al. (1990). A randomized, controlled trial of a geriatric assessment unit in a community rehabilitation hospital. *New England Journal of Medicine*, 322, 1572-1578.
- Beisecker, A. E. (1988). Aging and the desire for information and input in medical decisions: Patients consumerism in medical encounters. *The Gerontologist*, 29, 330-335.
- Beisecker, A. E. (1989). The influence of a companion on the doctor-elderly patient interaction. *Health Communication*, 1, 55-70.
- Beisecker, A. E. (1990). Patient power in doctor-patient communication: What do we know? *Health Communication*, 2, 105-122.
- Beisecker, A. E. (1996). Older persons' medical encounters and their outcomes. *Research On Aging*, 18, 9-31.
- Beisecker, A. E., & Moore, W. P. (1994). Oncologists' perceptions of the effects of cancer patients' companions on physician-patient interaction. *Journal of Psychosocial Oncology*, 12, 23-39.
- Breemhaar, B., Visser, A., & Kleijnen, J. (1990). Perceptions and behaviors among elderly hospital patients: Description and explanation of age differences in satisfaction, knowledge, emotions, and behaviour. *Social Science and Medicine*, 331, 1377-1384.
- Clark, J. A., Potter, D. A., & McKinlay, J. B. (1990). Bringing structure back into clinical decision making. *Social Science and Medicine*, 31, 1377-1384.
- Coe, R. M., & Prendergast, C. G. (1985). The formation of coalitions: Interaction strategies in triads. *Sociology of Health and Illness*, 7, 236-247.

- Cooke, C. (1997). Reflections on the health care team: My experiences in an interdisciplinary program. *The Journal of the American Medical Association*, 277, 1091.
- Cooley, E. (1994). Training an interdisciplinary team in communication and decision-making skills. *Small Group Research*, 25, 5-25.
- Eisenberg, D. M., Kessler, R. C., Van Rompay, M. L., Kaptchuk, T. J., Wilkey, S. S., & Appel, S. et al. (2001). Perceptions about complementary therapies relative to conventional therapies among adults who use both: Results from a national survey. *Annals of Internal Medicine*, 135, 344-351.
- Ellingson, L. L. (2002). The roles of companions in the geriatric oncology patient-interdisciplinary healthcare provider interaction. *Journal of Aging Studies*, 16, 361-382.
- Ellingson, L. L. (2003). Interdisciplinary healthcare teamwork in the clinic backstage. *Journal of Applied Communication Research*, 31(2), 93-117.
- Ellingson, L. L. (2005). *Communicating in the clinic: Negotiating frontstage and backstage teamwork*. Cresskill, NJ: Hampton Press.
- Elon, R., Phillips, C., Loomer, J. F., Denman, S., & Woods, A. (2000). General issues. In D. Osterweil, K. Brummel-Smith, & J. C. Beck (Eds.), *Comprehensive geriatric assessment* (pp. 1-40). New York: McGraw-Hill.
- Extermann, M. (2003). Studies of comprehensive geriatric assessment in patients with cancer. *Cancer Control*, 10, 463-468.
- Fagin, C. M. (1992). Collaboration between nurses and physicians: No longer a choice. *Academic Medicine*, 67, 295-303.
- Frank, A. W. (1995). *The wounded storyteller: Body, illness, and ethics*. Chicago: University of Chicago Press.
- Glasser, M., Rubin, S., & Dickover, M. (1989). Caregiver views of help from the physician. *The American Journal of Alzheimer's Care and Related Disorders and Research*, 4, 11.
- Gray, R. E., Greenberg, M., Fitch, M., Perry, N., Douglas, M. S., & Labrecque, M. (1997). Perspectives of cancer survivors interested in unconventional therapies. *Journal of Psychosocial Oncology*, 15, 149-171.
- Greene, M. G., Adelman, R. D., Rizzo, C., & Friedmann, E. (1994). The patient's presentation of self in the initial medical encounter. In M. L. Hummert, J. M. Wiemann, & J. F. Nussbaum (Eds.), *Interpersonal communication in older adulthood: Interdisciplinary theory and research* (pp. 226-250). Thousand Oaks, CA: Sage.
- Greene, M. G., Majerovitz, D., Adelman, R. D., & Rizzo, C. (1994). The effects of the presence of a third person on the physician-older patient medical interview. *Journal of the American Geriatrics Society*, 42, 413-419.
- Hammond, S. L., & Lambert, B. L. (1994). Communicating with patients about medication. *Health Communication*, 6, 247-252.
- Hasselkus, B. R. (1994). Three-track care: Older patient, family member, and physician in the medical visit. *Journal of Aging Studies*, 8, 281-307.
- Haug, M. R. (1988). Professional client relationships and the older patient. In S. K. Steinmetz (Ed.), *Family and support systems across the life span* (pp. 225-242). New York: Plenum Press.
- Haug, M. R. (1996). Elements in physician/patient interactions in late life. *Research on Aging*, 18, 32-51.
- Haug, M. R., & Ory, M. (1987). Issues in elderly patient-provider interaction. *Research on Aging*, 9, 3-44.

- Hummert, M. L., & Nussbaum, J. F. (Eds.). (2001). *Aging, communication, and health: Linking research and practice for successful aging*. Mahwah, NJ: Erlbaum.
- Jackson, P. B., & George, L. K. (1998). Racial differences in satisfaction with physicians: A study of older adults. *Research on Aging, 20*, 298-316.
- Labrecque, M. S., Blanchard, C. G., Ruckdeschel, J. C., & Blanchard, E. B. (1991). The impact of family presence on the physician-cancer patient interaction. *Social Science and Medicine, 33*, 1253-1261.
- Langhorne, P., Williams, B., Gilchrist, W., & Howie, K. (1993). Do stroke units save lives? *Lancet, 342*, 395-398.
- McCormick, W. C., Inui, T. S., & Roter, D. L. (1996). Interventions in physician-elderly patient interactions. *Research on Aging, 18*, 103-136.
- McHugh, M., West, P., Assatly, C., Duprat, L., Niloff, J., Waldo, K., Wandel, J., & Clifford, J. (1996). Establishing an interdisciplinary patient care team: Collaboration at the bedside and beyond. *Journal of Nursing Administration, 26*(4), 21-27.
- Miller, D. K., Morley, J. E., Rubenstein, L. Z., Pietruszka, F. M., & Strome, L. S. (1990). Formal geriatric assessment instruments and the care of older general medical outpatients. *Journal of the American Geriatrics Society, 38*, 645-651.
- Mishler, E. G. (1984). *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mosqueda, L., & Burnight, K. (2000). Multidimensional assessment in the ambulatory clinic. In D. Osterweil, K. Brummel-Smith, & J. C. Beck (Eds), *Comprehensive geriatric assessment* (pp. 187-202). New York: McGraw-Hill.
- Opie, A. (1998). "Nobody's asked me for my view": Users' empowerment by multidisciplinary health teams. *Qualitative Health Research, 8*, 188-206.
- Opie, A. (2000). *Thinking teams/thinking clients: Knowledge-based teamwork*. New York: Columbia University Press.
- Osterweil, D., Brummel-Smith, K., & Beck, J. C. (Eds). (2000). *Comprehensive geriatric assessment*. New York: McGraw-Hill.
- Owen, D. J., & Batchelor, C. (1996). Patient satisfaction and the elderly. *Social Science and Medicine, 42*, 1484-1491.
- Pendleton, D. A., & Bochner, S. (1980). The communication of medical information in general practice consultations as a function of patients' social class. *Social Science and Medicine, 14A*, 669-673.
- Reuben, D. B. (2000). Multidimensional assessment in the community. In D. Osterweil, K. Brummel-Smith, & J. C. Beck (Eds). *Comprehensive geriatric assessment* (pp. 173-186). New York: McGraw-Hill.
- Rosow, I. (1991). Coalitions in geriatric medicine. In M. R. Haug (Ed.), *Elderly patients and their doctors* (pp. 137-146). New York: Springer.
- Rubenstein, L. Z., Josephson, K. R., Wieland, G. D., English, P. A., Sere, J. A., & Kane, R. L. (1984). Effectiveness of a geriatric evaluation unit: A randomized clinical trial. *New England Journal of Medicine, 311*, 1664-1670.
- Rubenstein, L. Z., Stuck, A. E., Siu, A. L., & Wieland, D. (1991). Impacts of geriatric evaluation and management programs on defined outcomes: Overview of the evidence. *Journal of the American Geriatrics Society, 39*(supplement), 9S-16S.
- Ryan, E. B., Meredith, S. D., & Maclean, M. J. (1995). Changing the way we talk with elders: Promoting health using the communication enhancement model. *International Journal of Aging and Human Development, 41*, 89-107.

- Satin, D. G. (1994). The interdisciplinary, integrated approach to professional practice with the aged. In D. G. Satin (Ed.), *The clinical care of the aged person: An interdisciplinary perspective* (pp. 391-403). New York: Oxford University Press.
- Schmidt, I., Claesson, C. B., Westerholm, B., Nilsson, L. G., & Svarstad, B. L. (1998). The impact of multidisciplinary team interventions on psychotropic prescribing in Swedish nursing homes. *Journal of the American Geriatrics Society*, *46*, 77-82.
- Siegel, B. S. (1994). Developing interdisciplinary teams. In D. G. Satin (Ed.), *The clinical care of the aged person: An interdisciplinary perspective* (pp. 404-425). New York: Oxford University Press.
- Stahelski, A. J., & Tsukuda, R. A. (1990). Predictors of cooperation in healthcare teams. *Small Group Research*, *21*, 220-233.
- Thompson, T. L. (1994). Interpersonal communication and healthcare. In M. L. Knapp & G. R. Miller (Eds.), *Handbook of interpersonal communication* (2nd ed., pp. 696-725). Thousand Oaks, CA: Sage.
- Trella, R. S. (1993). A multidisciplinary approach to case management of frail, hospitalized older adults. *Journal of Nursing Administration*, *23*(2), 20-26.
- Vanderford, M. L., Jenks, E. B., & Sharf, B. F. (1997). Exploring patients' experiences as a primary source of meaning. *Health Communication*, *9*, 13-26.
- Wieland, D., Kramer, B. J., Waite, M. S., & Rubenstein, L. Z. (1996). The interdisciplinary team in geriatric care. *American Behavioral Scientist*, *39*, 655-664.
- Wieland, D., & Hirth, V. (2003). Comprehensive geriatric assessment. *Cancer Control*, *10*, 454-460.
- Zimmer, J. G., Groth-Junker, A., & McCusker, J. (1985). A randomized controlled study of a home healthcare team. *American Journal of Public Health*, *75*, 134-141.