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Communication with the elderly patient

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PREFACE

We would like to thank Dr. Donald Schuman for his assistance as an advisor to our thesis. We would also like to thank Dr. Nira Levine for her classes in Psyche Aspects and Patient Communications at Pacific University College of Optometry.

Introduction

Geriatric's patients are a part of the U.S. population who have been vastly overlooked for a long time. Optometry should be a part of the multi-disciplinary approach to the care of the elderly. There is a serious problem with many elderly people simply assuming that failing eyesight is a natural consequence of aging and consequently, they don't seek optometric services!

The number of Americans over 65 years is now growing twice as fast as the population as a whole.[2] The number of older citizens increased by 9.7% between April, 1980, and July, 1984, more than twice the 4.7% growth rate of the overall population in that period. Here is a state by state, 1984 population count of the elderly:[3]

A list by state of Americans 65 and older and their proportionate share of the population:

	Age 65 and Above	Share of Total
Florida	1,931,000	17.6%
Arkansas	336,000	14.3%
Rhode Island	138,000	14.3%
Iowa	410,000	14.1%
Pennsylvania	1,676,000	14.1%
Missouri	682,000	13.6%
South Dakota	96,000	13.4%
Massachusetts	777,000	13.4%
Nebraska	216,000	13.3%
Kansas	323,000	13.1%
Maine	152,000	13.0%
West Virginia	255,000	12.9%
Connecticut	407,000	12.9%
Oregon	344,000	12.8%
Wisconsin	611,000	12.7%
New York	2,247,000	12.7%
North Dakota	87,000	12.6%
New Jersey	942,000	12.5%
Minnesota	517,000	12.4%
Arizona	375,000	12.3%
Dist. of Columbia	75,000	12.1%
Oklahoma	401,000	12.1%
Tennessee	566,000	12.0%
Alabama	476,000	11.9%
Ohio	1,280,000	11.9%
U.S.	28,040,000	11.9%
Illinois	1,356,000	11.8%
Kentucky	438,000	11.8%
Mississippi	306,000	11.8%
Vermont	63,000	11.8%
New Hampshire	114,000	11.7%
Indiana	638,000	11.6%
Montana	96,000	11.6%
Washington	492,000	11.3%
North Carolina	688,000	11.2%
Michigan	1,007,000	11.1%
Delaware	67,000	11.0%
Idaho	108,000	10.8%
California	2,693,000	10.5%
Maryland	447,000	10.3%
Virginia	572,000	10.2%
South Carolina	331,000	10.0%
Georgia	577,000	9.9%
Louisiana	435,000	9.7%
New Mexico	135,000	9.5%
Nevada	87,000	9.5%
Texas	1,514,000	9.5%
Hawaii	94,000	9.0%
Colorado	280,000	8.8%
Wyoming	42,000	8.2%
Utah	128,000	7.7%
Alaska	15,000	3.1%

More than a million people over 65 years or older live in each of the seven states: California, Florida, Texas, New York, Illinois, Ohio, and Pennsylvania. Even the "oldest old" Americans, 85 years or more, exceed 2.3 million. In 15 years, the number will double to 5.4 million. By 2020 it will triple to 7.5 million. Each day, an average of 30 Americans become 100 years old.[4] As it stands, by the year 2000, 20% of our population will be over 65 years of age.[5]

With all these figures, it would behoove us to be more educated in all aspects of the care of this age group. Optometry's next challenge is the geriatric patient. No group is more rewarding, challenging, or requires more comprehensive eye examinations with emphasis on disease detection. No age group requires more exacting refractive services for optical fabrication with less tolerance for error. No age group requires of us as much innovation and knowledge of special type lenses and frames as the elderly patient.[6]

Theories of the Aged

Because of the relative paucity of scientific data, attempts to build comprehensive social-psychological theories of aging may be premature at this time, however, three major theories have been identified. The activity theory emphasizes that successful aging consists in maintaining the former life and activities as long as possible and finds little change in either the personal or the social system with aging, or if there are changes, both the society and the

person are expected to compensate for them. The disengagement theory emphasizes almost the opposite. In this view, successful aging involves the mutual withdrawal of both society and the individual from each other. The process is seen as for society because it insures its own continuity by replacing the aging individual with a younger person. The social reconstruction theory sees adjustment to aging as a dynamic , precarious process of interaction between the individual and his social environment. It can be a vicious cycle (as in the Social Breakdown Syndrome) or it can be a benign one (seen as spiral of personal mastery and positive social recognition). Inputs to the system come from practitioners (interested in the aging individual) and the political (concerned with the welfare of the aged population).[7]

Figure 1. THE SOCIAL BREAKDOWN SYNDROME: A vicious cycle of increasing incompetence

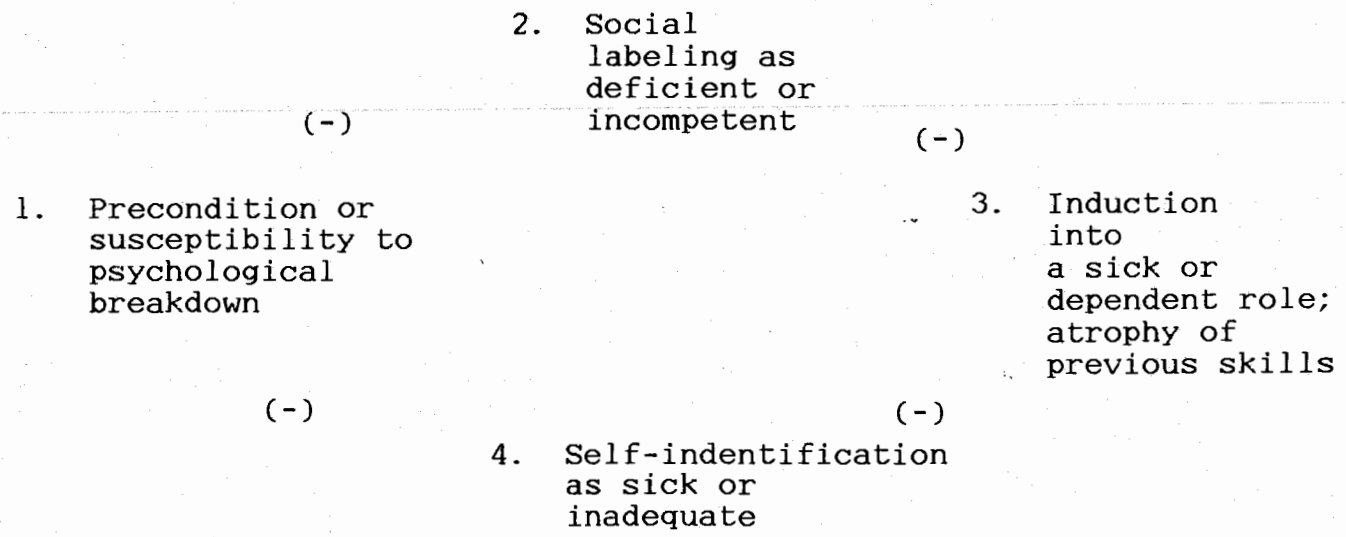
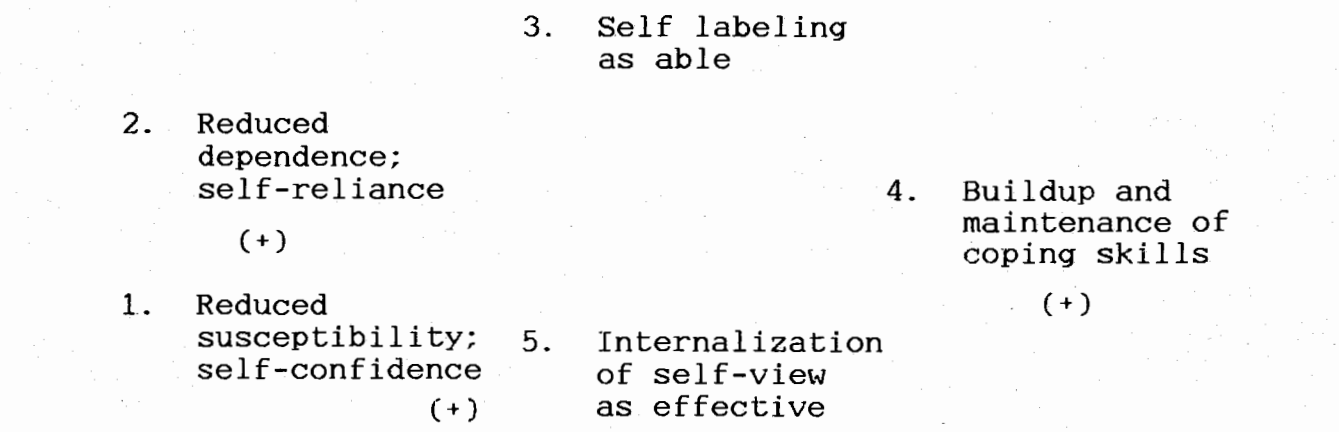


Figure 2. THE SOCIAL RECONSTRUCTION SYNDROME: A benign cycle of Increasing competence through social system inputs

INPUT B: Improved maintenance conditions (housing, health, nutrition, transportation)



INPUT A: liberation from the functionalistic ethic; evolution of alternate evaluations

INPUT C: Encourage locus of control; build adaptive problem solving

7b

Office Set-Up

Office design is important to the older patient. When constructing a new office or remodeling your present practice, keep the elderly patients in mind. Providing patients with coffee, tea, and cookies are small amenities; yet they are important to the older adult patient. They need your attention and are generally more sensitive to and appreciative of it.[8]

Ideally, the reception room should resemble the living room at home. Chairs with arms are preferable for the ease they provide the older patient. Set out at least one straight-backed, firm chair. Many older patients have difficulty rising from heavily upholstered furniture and will seek out a simple seat similar to a kitchen or dining room chair. Keep lighting soft, yet direct, to make reading easy. Don't use loud colors since they are not in keeping with the living room atmosphere you are trying to provide. Bright colors can actually upset some older adults. Warm pastels can be appreciated by all.[8a]

The corridors leading to the office and within the office should be wide enough for wheelchairs. An entrance ramp to the front door will be appreciated by patients in wheelchairs, and ambulatory older patients who have difficulty with steps. Carpeting should be used in your office as linoleum floors can be slippery.[8b]

Office location is equally important to older adults. An office in the residential areas is beneficial. As few

steps as possible is the ideal consideration for older patients. If an upstairs office is necessary, an elevator is a must. Downtown locations are still preferred by some. Convenient parking is helpful.[8c]

Help elderly patients maintain access to information by providing large-print materials. Stock large-print periodicals in your magazine rack. Consider printing appropriate patient information literature in large print. Maintain and distribute to your patients a reference list of periodicals that are available in larger print.[9]

Myths of the Aged

One must view aging as another stage of life rather than an insidious disease. The optometrist must grow in the determination to build compassionate, equitable partnerships with elderly patients for the benefit of both.[10] There are many myths associated with the elderly: One such myth is that the aged are isolated and neglected by family. The truth is that most prefer to be close to the immediate family but not to live with them. The stereotype is that the aged are sick and dependent, but in actuality, only 5% are institutionalized; 95% of the aged live in their own homes!

Age is as much psychological as it is physiological. Even though many have some decreased mobility, more than 93% of them deem their own general health as either fine, good, or excellent. People believe that the basic fear of the elderly is dying, but in actuality, it is loneliness; the optometrist must inform himself of the community organizations

for the senior citizens. The majority of the senior (about 3/4) are pretty much satisfied with their past. The young tend to think the aged are conservative and rigid; this may be true for some, but many are "reorganizers" who get involved in a different way after retirement and adapt well to society.[11a]

Dementia (chronic brain syndrome) is not the inevitable destiny of age nor it is widespread. A recent estimate indicated possibly 10% of the over 65 (highest concentration in those 85+) may experience brain disfunction. Most researchers feel that half of that percentage may have treatable, unrecognized systemic disease that have brought about the "pseudo-dementia".[10a]

Many of the accidents that the aged are involved in are due to vision rather than the fact that they are clumsy. Many of the accidents are due to falls which involve their bifocals. For these people, one might want to use ribbon bifocals.[12] The myth is that decreasing vision of the aged is a normal progression. The fact is that without any pathological or aging changes (such as cataracts) most can be corrected to 20/20 or better. Vision is an important part of the mobility of the aged - a service that the primary care optometrist is able to offer.[11b]

Frame Adjustment

Frame adjustments for the elderly follow the same general guidelines as with other folks except for some

special emphasis. The following guidelines are some things one might watch for in fitting the elderly.[12]

1. The skin at the nose is less firm.
   a.) Pads pull nose tissue into wads and the surface becomes uneven; therefore one must avoid use of rocking pads.

   b.) Saddle bridges with weight on the crest are recommended.

   c.) Make the lenses smaller and lighter (plastic-carbon fiber, proprionate, and optyl).

2. One might want to fit the earpieces a little looser on the back of the ears because of tender skin of the elderly.

3. Spring hinges should be used for nursing home patients since they frequently sleep with their spectacles.

4. If the individual is clumsy or frequently falls due to his vision, use a ribbon bifocal.

5. For some individuals use high add bifocals beause reading at a closer distance can be better for them.

6. Don't use dark cosmetic tints because night driving for the elderly is worse due to scattered light by the media (eye).
   a.) Advise them that they can close one eye and then switch to the other when hit by scattered light.

   b.) If any tint is used, use pin #1 to cut out the blue end of the spectrum.

7. If the individual is active, set the bifocal lower.

8. Use a scratch resistant coating on plastic lenses.

9. Use higher quality frames to resist shape changes.

10. Advise them of the importance of light for reading.

11. Advise them of the lessened range of focus.

12. Tell them of the adjustment period necessary to get used to bifocals, trifocals, and cylinder corrections.

Communicating with the Elderly

"The primary tool for the delivery of health care services to people is human communication."[13] Some of the problems encountered by the elderly in health care today are related to underlying problems in human communication.[13a] Kreps (1984) has identified some of these problems which include "dehumanization of patients by health care professionals lack of patient compliance with health care regimens and appointments, misunderstandings between patients and practitioners, cultural barriers between people in health care, and widespread dissatisfaction with the helper-helpee relationship by both patients and practitioners."[13b]

An illustration of the dehumanization is given by Charotte Epstein in Learning to Care for the Aged. "It is not surprising that professionals engaged in care of the aged are too often insensitive in their needs. Take the case of the old man who speaks hesitantly because he knows that his memory has been affected and he is reluctant to reveal his debility. He speaks in a very low voice, and slowly. His physician, a well-known geriatrics specialist, sees him every five or six months for a rather superficial examination. In the course of the examination, he will ask in a voice unnecessarily loud, "How are you feeling?". He never waits long enough for the old man to respond. After two seconds he will turn to the man's paid companion and ask in amore normal voice, "How does he feel?". The patient is left in even greater self-doubt, more disheartened than ever before, since to him it

has become clear that he no longer has the ability to communicate effectively.[14]

Two thirds of the elderly are relatively well and require simple and straightforward interventions.[15] The remaining one third often have multiple problems as physical health problems, social isolation, economic deprivation, and an inability to carry out the activities necessary for independent living.[15a] Pfeiffer (1985) stated that "only an integrated multi-disciplinary approach has any realistic chance of returning the multiply impaired older person to normal or near-normal functioning".[15b]

From the above accounts, the need for optometrists to be effective communicators is evident. The following ideas on communicating with the elderly are presented in order that the optometrist may help alleviate some of the problems faced by the elderly in health care today.

Since the success of almost any treatment depends on the adequacy of the initial history, both the patient's verbal and nonverbal communication are important in transmitting information to the clinician for use in evaluation and management plans.[16]

The first step is to approach the elderly person with respect by knocking before entering the examining room and greeting the patient by their surname and not their given name unlss they request it.[16b] "Touch may be an

effective way to relax and make contact with the elderly patient. As a rule, the elderly are less inhibited by physical touch. Holding the patient's hand or resting your hand on his arm may be very reassuring.[16c]

In communicating with the elderly, speaking clearly and slowly can be very effective, especially with those patients who have hearing loss or organic brain disease.[16d] To hold their attention, it is helpful to repeat their name during the conversation.[17]

An elderly patient will appreciate a good listener and not feeling hurried is one thing older adults like most.[8d] Being a good listener helps build the human rapport older patients greatly appreciate.[8e] Additionally, "an obvious interest in what the patient is saying, well-directed questions, a friendly encouraging attitude, and a systemic approach to obtaining information will do much to ingratiate yourself with the patient while you are performing a thorough exam.[8f]

A slow and relaxed pace in the interview will help decrease anxiety and will give elderly patients enough time to respond to the doctor's questions.[16c] On the other hand, some older adults often talk a lot and it helps to listen to their stories for a short time and then tactfully change the subject by asking them questions.[8g]

In giving directions, an older patient may have difficulty if they are complicated and given rapidly. Therefore, it is better if they are given slowly and deliberately and tactfully repeated and the patient is then questioned about

his understanding.[17a] Between 50 and 70 percent of what you tell your elderly patients is forgotten when they leave your office and one solution is either written instructions or have a family member accompany them.[18]

Since some ten percent of older persons suffer from memory impairment and are not able to provide full or accurate information, family members can provide information about the older patient's health, social and occupational background and their current state of health.[15c] The family member should be included with the patient's permission and Wick (1979) has pointed out to be sure to direct your explanation and concern to the patient because "unless the patient is suffering from advanced senility, it's disrespectful to treat him as though he's not responsible for himself."[8h]

The success of surgical-medical care of the elderly patient depends on their trust and compliance and Mead (1977) stated that "compliance by demand may help a little, but compliance by friendly persuasion may help a great deal."[17b] Haug (1979) in a study of doctor-patient relationships stated that his findings suggested that "currently physicians are more likely to find that those over 60 are willing to accept their authority and not give them an argument over treatment or diagnosis".[19] He hypothesized that societal trends will modify these conditions in the future since younger patients are more critical of authority.[19a] Consequently, "all of this suggests that physicians in dealing with patients

maybe called upon to rely on their powers of persuasion and explanation if they wish to avoid rejection of their advice, since they will be less able to count on their institutionalized authority."[19b]

A number of factors, both patient and physician, influence communication with the elderly. Patient factors are anxiety, unrealistic views of the physicians, persistant themes, fear of losing control, and death.[16f] Another patient factor is hypochondriacal inclinations.[17c] Physician factors concern attitudes toward the elderly and lack of understanding.[17d]

Since many elderly individuals may function at a high level of anxiety, a new situation such as a visit to a doctor's office may trigger intense anxiety and affect the elderly individual's ability to communicate.[16h]

The elderly patient may develop an unrealistic view of the physician by a process called transference.[16i] The elderly patient may view the physician as a parent, which may lead to instruction giving or inquires into the physician's health and behavior.[16j] Blazer (1978) noted that a positive transference, if handled properly, could be of benefit in the management of a patient.[16k]

The elderly patient may communicate with the physician by means of persistent themes. In the somatic concern theme, the patient may spend much time complaining of ailments or recounting histories of their bodily functions.[16l]

The loss reaction theme is evident in an elderly person when they spend considerable time talking about their losses, including loss of friends and loved ones, loss of physical functioning, loss of self-esteem, and loss of employment and previous activities.[16m] The tendency in the elderly, due to disillusion and the realization of approaching death, to reflect and reminisce is the life review theme.[16n] Another theme is the fear of losing control whether it be physical or mental functions, for example, the fear of "going crazy" is one of the greatest fears of late life.[16o] The last theme Blazer (1978) mentioned was death and he pointed out that the elderly are not obssessed with death but rather the fear of of being alone at the end of life.[16p] Mead (1977) stated that hypochondriacal inclinations are common in elderly patients since they receive personal attention from their persistent complaints, which serves as an excuse for them to be dependent and not accomplish more in daily activities.[17c]

The single most important element in the management of the older patient is the O.D.'s attitude.[8i] Yet, it is common in our youth-oriented society to find fears of aging and death and the physician's personal feelings about these issues is important when communicating with the elderly.[16q] Sometimes physicians show a lack of understanding and they must attempt to separate myths from reality about the aging and they must guard against labeling and sterotyping.[16r]

Another important point is that older patients are treatable and are highly responsive to medical, surgical, psychiatric and rehabilitative interventions.[15d] On the other hand, physicians feel somewhat threatened by the elderly because they have often had diseases they can't recover from or recover only for a limited period of time.[17f] Additionally, physicians may be threatened by the emotional demands of the elderly patient who have an intense need for attention and sympathy.[17g]

Denzig (1985) reported that 25% of the elderly have significant mental health problems and that depression is often not focused on by physicians and feelings are ignored.[18a] He also pointed out that the highest rate of successful suicide occurs in elderly males over the age of 85 and if the elderly talk of depression and suicide, they must be taken seriously.[18b] The physician should be alert for nonverbal signs, such as facial expressions, gestures, postures, and touch, which can provide considerable information about conditions such as depression or anxiety.[16s]

Communicating Techniques for Special Patients

Some elderly persons have conditions which require special communication techniques. These conditions are hearing loss or deafness, dysarthria, confusion, aphasia, and vision loss. Anger is an emotion encountered in the elderly which must be understood and dealt with.

There are two major types of hearing loss: conductive or sensorineural. A conductive hearing loss involves the outer or middle ear and causes include congenital malformations of the outer ear, foreign objects or excess wax plugging the canal, otitis media (infection of the middle ear), and otosclerosis (sponge bone forms within the bony capsule of the ear).[20]

Because of the air conduction loss, the elderly person may not be aware of the noise around him and the need, therefore, to speak louder and he will understand what is said to him if it is said loudly enough.[20a]

A malfunction in the inner ear or damage to the neural pathway from the cochlea (inner ear) to the brain results in sensorineural hearing loss.[20b] Here the perception of sound is impaired and the person speaks with excessive loudness because of impaired bone conduction.[20c] Sounds of high frequency (eg., s, sh, t, ch) are hard to discriminate and word confusion results.[20d] Causes may be congenital or acquired via injury, toxic effects of drugs, or aging.[20c] Whereas a conduction loss can be reversed through medical or surgical treatment, there is no surgical or medical treatment for sensorineural hearing loss.[20f] A combination loss can also occur.

The following suggestions are taken from Communication Management of the Geriatric Patient:[20g]

1. Give important instructions in a quiet environment.

2. Check to make sure a hearing aid is on and it is on microphone ("M") for daily use and not telephone ("T").

3. When talking with the patient make sure your face is visible and have him watch you as you speak.

4. Keep windows or bright lights behind the patient so he doesn't have to look into glare.

5. Don't shout - speak slowly and clearly as loudness will distort sounds.

6. Be careful not to exaggerate sounds as cues from watching your lips are more difficult to pick up then.

7. If the patient doesn't hear you, repeat or rephrase what you say and if he still has difficulty, try writing or painting.

Brain injury or nerve damage can result in paralysis, paresis, or incoordination of the muscles of the lips, tongue, jaw, palate, larynx, and breathing mechanism and the speech problem is called dysarthria.[20h] Dysarthria may result from Parkinsonism, Progressive spinal muscular atrophies, CVA's, infectious multiple sclerosis, and chronic alchoholism.[20i] The dysarthric patient may speak too rapidly or too slowly and his speech may be distorted, slurred, and irregularly produced.[20j] Other characteristics are a breathy voice, a marked air wastage, too shallow or too deep breathing, weak intensity of voice, hoarse or strained and strangled voice, monotone, monopitch, monoloudness, and hypernasality or hyponasality.[20k]

The following are suggestions for communicating with the dysarthritic patient:[20h]

1. Communicate in a quiet environment.
2. Get the patient's attention by touching him on the shoulder and having him look at you and call him/her by name.
3. Ask simple, direct questions which can be answered with a single word or short phrase.
4. If the patient drools, remind him to hold his head erect and swallow frequently.
5. Avoid shouting, since hearing is not affected.
6. Remind the patient to take his time and speak slowly when talking.
7. Encourage the patient to say one word at a time.
8. Increasing volume of his voice will slow down his rate.
9. Maintain a calm attitude.
10. Paper and pencil should be available for him to write questions and answers. For people who also have vision problems, a large felt tip marker and wide lined paper also helps.

Confusion can result in the elderly due to generalized brain disturbance, such as arteriosclerosis or senile brain disease.[20m]

Common characteristics are "disorientation to time and place; short term memory loss; difficulty "tuning in" to what is said; impaired comprehension; rambling and incoherent speech, and inability to function on an abstract level.[20n] The patient may experience delirium and/or hallucinations and also depression, paranoia, and agitation.[20o]

The following are suggestions for communicating with the confused patient:[20p]

1. Encourage correct orientation by reminding him often of his name, the date, where he is.
2. Have the patient's attention before asking or telling him something.
3. Give the patient time to process what is said to him. Ask simple and direct questions.
4. Speak slowly and distinctly but without unnecessary loudness.
5. Speak in a friendly manner, but do not treat the patient as though he were a child.
6. Look at the patient while you are talking to him.
7. If the patientrambles from the original subject, stop him by saying, "Mr. Smith, I didn't understand that. What did you say about _____?"

Feil (1978) offered these suggestions when communicating with the confused elderly patient[21]:

1. Attempt to interpret the patient's physical actions when feelings can't be expressed with words.
2. If the patient uses personally constructed non-dictionary words, repeat the words, emphasizing the key words in their sentences. Three needs these patients seem most often to express are: the need to belong, the need to be useful, and the need to express strong feelings of of anger, sadness, or love.
3. Disoriented people are sensitive to your feelings and attitudes, so listen with genuine, full attention.
4. The confused patient, if taken up with a particular fantasy, won't listen to you if confronted with "the truth " instead they may withdraw or become hostile.

5. Express the emotional need of the person
6. Use touch. Touch the person on the shoulders.

Sedatives and tranquilizers, used injudiciously, may create or aggravate confusion.[17h] Additionally, physicians should realize that delirium or increased confusion is a valuable warning sign and the physician should be alerted to the probability of a developing complication in the patient's physical condition.[17i]

A communication problem known as aphasia may occur following an injury to the left side of the brain, due to stroke, tumor, or an accident.[20q] The patient may have a paralysis or weakness of the right side of the body and the ability to use words or symbols is reduced.[20r] The aphasic patient still can think, recognize family and staff, find his way, and remember schedule, but difficulty arises when understanding speech, speaking, reading, writing, and dealing with arithmetic processes.[20s]

The following suggestions are helpful in communicating with the aphasic patient:[20t]

1. Do not discuss his physical or mental condition in his presence. Although he may understand very little, he can still attend to body language.
2. Provide visual cues (pointing, etc.) when communicating.
3. Treat the patient like an adult. Baby talk would be demoralizing and defeating.
4. Before speaking, touch the patient on the shoulder, have him look at you, and preface your remarks by saying, "Mr. Smith".

5. Speak slowly with natural pauses as more time is needed to process what is being said and rapid speech is difficult to interpret.

6. Keep your communication short and simple and accompany it with gestures.

7. Questions should be simple, direct, and answerable with "yes" or "no".

8. Do not talk for the patient unless absolutely necessary and do not interrupt him.

9. If the person has a right hemiplegia he will often have a right field cut so stand slightly to the left where he can see you when you talk to him.

10. It is important to remember that an aphasic person has not lost his ability to think and remember and his feelings, likes, dislikes, and his memories will be the same.

Mehr and Freid (1975) discussed the impact a vision loss can have on communication, specifically, hearing, feelings and eye contact.[22] People who suffer a vision loss often complain of increased difficulty in hearing because of missing visual cues that help clarify partly audible communication.[22a] Additionally, non-verbal communication by body contact or visually observed body language often expresses the emotional content of a communication and the person misses these cues.[22b] Eye contact in our society is very important and often the lack of eye contact in communication with the visually impaired often leads to vague feelings of discomfort by sighted participants.[22c]

The duties of an optometrist are two-fold. First, he must review his known gestures and facial expressions with

an awareness that the messages are lost to his patient with low vision, and he can substitute for this loss.[22d] Secondly, he can educate family, friends, employees, teachers, and the partially-sighted themselves because they may never realize the amount of visual communication they are using or that is not to be received in part.[22e]

Conditions that cause anger in the elderly are distress, dreadful behavior, delirium, drug reactions, depression, and dementia.[23]

The contributing features and/or reactions of these conditions are as follows: [23a]

Distress	Catastrophic reaction when overwhelmed by high expectations and demands.
	Frustration and anxiety about declining health and loss of special senses.
	Frustration at difficulty in coping with medical devices and regimens.
Dreadful Behavior	Previous mental illness.
	Paranoia, agressive traits, and dependence on drugs or alchohol.
	Anxiety, loneliness, few visitors.
Delirium	Hallucinations and delusions due to one or more physical illnesses.
	Symptom exacerbation at night.
	Belligerent behavior that comes and goes.
Depression	Presentation disguised as altered behavior (eg., asocial, antisocial, or irritable behavior or occasional verbal and physical abusiveness).

Dementia	Catastrophic reactions. Deterioration of judgement, self-control, and memory. Disinhibition, allowing for expression of antisocial or irritable behavior.

An angry or violent outburst from an elderly patient is rarely meant personally.[23b] The patient may be reacting defensively to a delusional interpretation of the world which may be aggravated by hearing and vision difficulties.[23c] Listen sympathetically and try to correct the patient's viewpoint through talk.[23d] Let the patient decide where to sit but don't allow yourself to be trapped in a small room with the patient between you and the door.[23e] A visual defect from a catarat or homonymous hemionopia makes the world more threatening to the patient so position yourself where the patient can see you clearly at an angle about 45° to 90° to the patient.[23f] Offering food or a cold drink to the patient may help as it is difficult to eat and be angry.[23g] In order to correct a patient's misapprehensions, you must first know what they are, therefore, open-ended questions and paraphrase the patient's remarks to ensure that you understand and the patient feels understood.[23h]

One of our responsibilities as optometrists is to be knowledgable about information, programs and referral services available to the elderly.

Social Services for the Elderly

Information services and referral services are available from the Social Security office, the Department of Public Health, and the local Area Agency on Aging (AAA) in each state.[24] Published booklets and directories describing programs, services and facility's directories describing programs, services, and facilities are provided by many communities.[24a]

Some phone directories contain blue pages entitled, for example, a Guide to Human Services. Phone numbers under Senior Services come under the general headings: information (Senior Services Divison, Council on Aging); Advocacy (Legal Services, Community Action Program); Employment (County, Senior Job Center, State Employment Division Green Thumb); Nursing Home Hotline Protective Services, Senior Centers, Transportation (Senior Buses) and utilities (Electric Services for Seniors).

Programs for the elderly are: Social Security Income, Medicare and Medicaid, Supplemental Security Income, and Programs under the Older American Act of 1965.

Information regarding Social Security eligibility and benefits can be obtained at the nearest Social Security office. The usual age of retirement is 65, however, the elderly can retire as early as 62 but the retirement check will be less than that available at age 65 and the differential is permanent.[24b] Monthly checks are sent to workers and

their dependents when the workers retire, become severely disabled or die.[24c] The Social Security Administration administers the program.

Medicare is a health insurance program for people 65 or older and some persons under 65 who are disabled and it is run by the Health Care Financing Administration under Social Security.[24d] Medicare consists of two parts: Hospital insurance (part A) and medical insurance (part B). "Hospital insurance (part A) can help pay for inpatient hospital care and, after a hospital stay, for inpatient care in a skilled nursing facility and for limited care in the home by a home health agency."[24c] "Medicare insurance (part B) can help pay for doctor's services, nurse practitioner's services in rural health clinics, outpatient hospital services, outpatient physical therapy, speech pathology services and a number of other medical services and supplies not covered by hospital insurance."[24f] Medicare does not pay the full cost of some services and sets time limits for hospital and skilled nursing facility stays and for visits of professionals.[24g] You can obtain a Medicare Handbook from the Social Security office nearest you. Currently, if an optometrist provides examination services related to the condition of aphakia, medical insurance will cover the optometrist's services.[25]

Medicaid is a federal-state program under Title XIX of the Social Security Act (SSA), that finances medical services

for public assistance recipients and those deemed medically indigent.[24h] Either an older person must meet the eligibility criteria for Social Security Income (SSI) or they must reside in a state that will include persons whose incomes are higher than the SSI limit but whose medical expenses threaten them with indigency.[24i]

Supplemental Security Income (SSI) is available for persons 65 or older or the blind or disabled who have little or no regular income and few assets.[24j] Money for SSI comes from general funds of the U.S. Treasury and is administered through SSA. The states may supplement federal payments, provide Medicare, food stamps, and/or various social and rehabilitative services.[24k]

1973 amendments to the Older American's Act of 1965 created new community organizations in each state called Area Agencies of the Aging (AAA) in order to plan and coordinate services for the elderly.[24l] The Older American's Act authorized funds for state and substate agencies for planning and coordinating services, for training professionals and support of research in the field of aging, for the construction of multipurpose centers, for the development of congregate meal programs, and for employment opportunities for the elderly.[24m]

The local Regional Transportation Authority by law must provide transportation for the elderly and handicapped and specific information can be obtained from the Regional Transportation Authority, Council on Aging, or AAA.

Information on meal programs, employment opportunities, housing subsidies, food stamps, and legal aid can be obtained from Area Agencies for the Aging (AAA's) or local sources.

Commmunity Action Programs are designed to serve low-income people in areas such as housing, advocacy, and welfare rights.[24n] Many local communities provide emergency funds for rent or food and assistance can be obtained from the Salvation Army, Red Cross, churches, and community fund organizations.[24o]

Home Health Services, provided by skilled nurses, home health aides, occupational therapists, and physical therapists, can provide care at home to the elderly and it may be reimbursed to some extent by Medicare and Medicaid.[24p]

The Community Mental Health Act of 1963 provided for services for the elderly in community mental health centers and in the client's home or at senior centers?[24q] Nursing homes which qualify for remibursement by Medicare and Medicaid legislation are extended-care facilities, skilled-nursing facilities, and intermediate care facilities.[24r] Extended care facilities and special units within hospitals are for acute care patients whereas skilled-nursing facilities provide 24-hour care by registered and practical nurses for long-term convalescent and terminal clients, and intermediate-care facilities are for those patients who need help with problems of daily life and with administration of daily medications.[24s]

The New Old: Struggling for Decent Aging, is an excellent book which contains an inventory of innovative programs for the elderly, resources for self-reliance, a bibliography of books and magazines dealing with aging and issues pertinent to aging, and a comprehensive listing of organizations, services, and networks.[26]

Specific Eye Conditions of the Aged

"There are three specific conditions that effect more than one percent of people aged 65 or more:

(1) Cataracts (other than prenatal) effect in the order of 5% to 7% (6.17%) of elders, or more than 1 out of every 29 people aged 65 or more.

(2) Glaucoma effects in the order of 3% to 5% (3.79%) of elders, or 1 out of 20.

(3) Retinal disorders other than diabetic retinopathy effect in the way of 1% to 3% (1.90%) of elders, or approximately 1 out of 50 older people."[27]

"Several other conditions effect 2 to 8 elders per 1,000:

(1) Myopia effects in the order of 6 to 8 per 1,000 elders.

(2) Uveitis effects in the order of 4 to 6 per 1,000 elders.

(3) Cornea or sclera problems effect in the order of 3 to 5 per 1,000 elders.

(4) Diabetic retinopathy effects in the order of 3 to 5 per 1,000 elders.

(5) Optic nerve disorders effect in the order of 2 to 4 per 1,000 elders."[27a]

Cataracts and glaucoma are nearly eight times more prevalent among elders than in the general population while the risk of retinal disorders is approximately six times greater for elders than the general population.[27b]

"Congenital or developmental opacities typically located in the area of the fetal nucleus are technically cataracts but are usually innocuous and non-progressive."[28] "If presented in the context that their presence is a lifelong phenomenon and indicate no potential threat to visual function or if the changes have been deduced to be the cause of uncorrectably reduced vision (i.e. amblyopia), then the mention of such opacities (cataracts) to the patient is appropriate."[28a] "Unless the above two conditions are met, the diagnosis of cataract for a teenager or young adult could have phsychological implications and even a stigma attached."[28b] If the above guidelines are followed, the term cataract is reserved in patient discussion to lenticular opacification which diminishes visual function."[28c] "Patients would be informed that they had cataracts when they became uncorrectably symptomatic or if asymptomatic with reduced vision, which cannot be corrected or cannot be attributed to another cause."[28d]

Before explaining about cataracts to the patient, it would be beneficial to clear up any misconceptions by asking the patient what they think a cataract is, what problems can it cause and what is done for it.[28e]

Some optometrists feel that any opacification should be mentioned to the patient since they may be told by another physician which would discredit him/her in the eyes of the patient.

"If the patient is asymptomatic, they should be provided with a minimum of the following facts:

(1) Changes within the lens of their eyes have been identified.

(2) They indicate no immediate threat to vision.

(3) The potential exists that they will, in time, progress to the point of being a functional problem.

(4) There is nothing to be done to reverse or halt them as they are a part of the normal aging process."[28j]

An eye model or clear diagrams used when educating the patient would be helpful.[28f] "While exact language and delivery will obviously vary, the message the patient should receive is that their senescent cataract represents one point on a life long continuum of lenticular change."[28g] "An earlier point in this evolution was the need for spectacle correction at nearpoint."[28h] "Cataract, the loss of lenticular transparency, is quite simply one further manisfestation of the body's overall aging process and like graying of the hair begins at different times and proceeds at different rates for different people."[28i] Do not use the term senescent as it may imply to elderly patient they are going senile.

"Surgical consultation is sought when the visual deficit is causing undesireable alterations in daily activities and life styles and when the patient is functionally satisfied but is difficult to visualize the macular area ophthalmoscopically."[28k]

The pre-surgical patient must understand that his or her optometrist is coordinating their efforts with the surgeon and is available to discuss potential options and outcomes and they will be available for post-operative care.[281] In pre-surgical counseling one should not provide absolute guarantees as to ultimate visual prognosis.[28m]

"Glaucoma is the second leading cause of blindness in the United States, with approximately one out of 50 Americans above the age of 35 having the condition."[29] All patients, especially the elderly, should be educated about glaucoma and have their eye pressures checked and a complete eye exam yearly after age 45. Students should be examined every year while in school and then every two years until age 45 unless otherwise indicated. It should be emphasized to patients that glaucoma is a silent disease and thatthey could start losing vision without realizing it. The importance of yearly exams with tonometry measurements should be emphasized and the patient should be told that with early detection of glaucoma, the disease can be contained but if left untreated, peripheral (side) vision can be lost and eventually central vision and total blindness can occur.[30] "When glaucoma becomes more advanced, it may be accompanied by blurred vision, a loss in side vision, the appearance of colored rings around lights, and pain or redness in the eye(s)."[30] Patients should be educated as to the symptoms of glaucoma.

Breaking bad news to a patient is never easy and Dr. Nira Levine in her Patient Communication's class at Pacific University provides the following guidelines:

1. Think before you speak and decide what you are going to say.

2. Be brief and say it as simply as you can using layman's terms.

3. If you use an optometric or technical term, immediately define it.

4. Whenever possible, combine visual aids with a verbal explanation.

5. Start with the familiar and proceed to the unfamiliar using an introductory statement that has to do with your examination findings or their chief complaint. In this way you are preparing them that your findings are not just going to be okay. Example: "Remember when I shined the light in your eyes, unfortunately when I looked in there, I saw some changes...."

6. Use the word "we" rather than "I" or "you" because it indicates a shared responsibility.

7. Use non-verbal as well as verbal approaches. Lean forward, maintain eye contact, and if the patient is upset, reach out and touch their shoulder or arm.

8. Encourage your patients to express their feelings and have an accepting attitude between the patient's feelings and reactions. Example: I can understand how upsetting and frightening this information must be."

9. If you are sending them for a consultation, provide them with the names of two doctors with whom you are familiar with and assure the patient that you will be continuing to provide their care. Have your receptionist make the appointment.

10. Ask them at the end if there is anything else you would like me to review with them or anything they don't understand.

11. Provide your home phone number so they know they can call you if they have further questions.

12. If the patient is having difficulty with understanding such as beginning senility, ask them if it would also be suitable to discuss this with a spouse or other relative.

13. If it is a consultation, inform the patient that the consulting physician will be repeating some of the same tests to make sure the condition is valid.

14. Tell the patient you will be sending the consulting physician a complete record of today's examination.

Senile macular degeneration is a common cause of vision impairment and legal blindness in the United States.[32] Because senile has a bad connotation, "age-related maculopathy" is a more appropriate term today. One doctor explains age-related maculopathy to his patients this way: "You have an eye condition we call age-related maculopathy. It affects a place on the back of the eye called the macula, hence the word 'maculopathy'. The macula is that portion of the seeing part of the eye, the retina, that you would use to look directly at my nose,. You use your peripheral vision -or side vision- to see my ears, hair, and my shirt. Your condition is associated with getting older and it is not specifically related to other diseases."[32a] After an understanding of the disease is established, then any other issues such as low vision care or laser therapy are pursued.[32b]

Elderly patients should be educated to the symptoms of retinal detachment. If they experience flashing lights (photopsia), vitreous floaters, or both, they should seek immediate help from an eye care professional. The elderly patients can be told that floaters (black strings or tiny black spots , mosquito like forms seen on a white wall) are a normal sign of aging but if the patient notices a

sudden burst of floaters, he or she should seek professional care. Another symptom of a retinal detachment could be compared as a thin tissue inside the back of your eye which tears somewhat like wallpaper can tear loose from the walls of a room.[33]

Diabetic retinopathy is the most important cause of adult blindness in the United States and in the United States a diabetic person has over a twentyfold chance of being blind compared with his non-diabetic counterpart.[29a] Diabetic elderly patients must be educated as to the need for continuous follow-up care and regular examinations so that any retinopathy may be detected and consequently referral for photocoagulation and vitrectomy if needed can be done in a timely matter. They also need to know that it is <u>assumed</u> that good control of their diabetes delays the onset of retinopathy.[29b] Additionally, diabetes may cause several other serious eye troubles, including cataracts, bleeding and a type of glaucoma and diabetics should be educated about these.[34] "One of the milder, often temporary effects of diabetes is a change in the focusing power of the eye. Eyeglasses or contact lenses might suddenly seem "too strong" or "too weak". Abrupt changes in vision, when no other cause can be found may be the first sign of diabetes.[34a]

"Contact lenses, eyeglasses, and intraocular lenses are all common forms of post-cataract vision correction."[35] The adjustment to contact lenses and eyeglasses requires good patient communication.

Some elderly people are hesitant about contact lens wear, sometimes the assurance "don't worry about it, we will take care of everything"[36] gives them the courage to try. The person who instructs the contact lens patient should have a lot of patience because it may take a number of visits to learn proper application and removal.[36a] Bringing a family member along is helpful as they will be able to assist him or her in minor emergencies.[36b] A printed instruction book and written wearing schedule should also be provided.[36c] Sometimes when applying a lens, a trembling hand may be steadied by crossing two fingers when placing a lens on the eye.[36d] Other contact lens hints are:[37] Wear spectacles until the lens is on the finger and is ready to be applied and put brightly colored stick-ons on each bottle to identify the cleaner, wetting solution, etc.

With a spectacle correction, the patient should be told beforehand that "he will probably see 20/20, read, and watch TV clearly, even drive, and perhaps continue his work, but it will not be the kind of vision he once had. Further, he is not alone as this condition is shared, normal and expected."[38]

The patient, when wearing spectacles, should be warned that the magnification of the lenses will make the walls curve in with the floor appearing to rise and the ceiling

descending.[38a] Different parts of the ceiling will rise and fall while walking and a circular scotoma in the periphery will produce a jack-in-the-box phenomenan with objects popping into and out of view.[38b] The 33% magnification causes objects to appear to be third closer and so the person must learn to reach further than he thinks and relearn to pick up plates and pour coffee, etc.[38c] Optical distortion allows best acuity in the central area of the lens so the patient must learn to turn his head fully from side to side and to be aware that cars may be hidden in his periphery unless he keeps his head moving and always keeps alert.[38d] The paitent will also have to virtually learn to dress and undress himself again and to judge distances on steps, curbs, and inclines.[38e] Needless to say, it will take patience on the part of the patient and his or her family during the adjustment period.[38f]

In presbyopia, the lens of the eye has lost it elasticity to focus on near objects and consequently the range of focus has decreased. Onset of presbyopia is around the mid-forties and to compensate for this one needs either reading glasses, bifocals, trifocals, or contact lenses. If one wants to get away from the traditional lines of bifocals or trifocals, many people can adjust to progressive no-line lenses.

There is a period of adjustment for the bifocals because of the "jump" of the image when looking from the far distance portion of the lens to the near segment.

Elderly patients should be advised that there is an adjustment period because of the image jump and they will also have to get used to walking up and down stairs again. Ribbon bifocals should be ordered for those people unable to adjust to bifocals when walking (looking down).

With the elderly population increasing, optometrists will find they are taking care of a greater percentage of geriatric patients in their practices. Keeping in mind that each elderly patient is a unique individual, it is hoped that the information and insights in communicating with the elderly presented here will help foster the humane care and understanding they so rightly deserve.

A variety of pamphlets pertinent to the elderly patient are available from:

(1) American Optometric Association
Attention: Order Department
243 North Lindbergh Boulevard
St. Louis, Missouri 63141

Common Vision Problems (astigmatism, myopia, hyperopia, presbyopia)
Astigmatism
Glaucoma
Cataract
Lazy Eye
Myopia (nearsightedness)
Hyperopia (farsightedness)
20/20
Answers to Your Questions About Low Vision
Presbyopia
Eye Coordination
Bifocals/Trifocals
Seeing Spots and Floaters
Managing Contact Lens Removal

So You Want to Wear Contact Lenses
So You Want to Wear Hard Contact Lenses
So You Want to Wear Soft Contact Lenses
So You Want to Wear Extended-Wear Contact Lenses
So You Need Specifically Designed Contact Lenses
A Good Look at Sunglasses
Driving Takes Seeing
Open Your Eyes to Vision in Driving Safety
Driving Tips For Older Adults.
Your Vision, The Second Fifty Years
Give Yourself a Lifetime of Good Vision
Eye Safety on the Farm
Hunting and Vision
Seeing with Style
Vision and the VDT Operator

(2) Better Vision Institute
230 Park Avenue
New York, New York 10017

Sunglasses
Eyeglasses for your Special Needs
Safety Eyewear for Work or Play
Refractive Error
A new look at ....Contact Lenses
Low Vision
Driving and Vision
Vision Problems of the Aging
Astigmatism
Care of Your Eyeglasses
Why should I have my eyes examined? Nothing hurts.
Diabetes and Vision
Your new lenses will be Impact-Resistant but.....

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