

ENHANCING COMMUNICATION WITH OLDER PATIENTS IN THE OUTPATIENT SETTING

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You are an internal medicine resident seeing patients in the continuity clinic. Your next patient, Mr. Howell, is an 89-year-old man with Alzheimer's disease as well as hypertension, atrial fibrillation, diabetes, osteoarthritis, cataracts, and hearing loss. Mr. Howell is accompanied by his wife, who made the appointment because Mr. Howell recently has complained of stomach pain.

Mr. and Mrs. Howell have been your patients for the last 2 years. Mrs. Howell is 88 years old and has several chronic illnesses. Mr. Howell's ability to care for himself has been slowly declining, and Mrs. Howell has been assuming more of his care. At Mr. Howell's last visit, you noted that Mrs. Howell seemed very fatigued.

Prior to entering the exam room, you run through a mental list of tips for communicating with older patients, which you learned at a recent workshop. You recall that the speaker suggested envisioning older patients as your grandparents and speaking to them as you would want a doctor to speak to your grandparents. You recognize that you should combine general techniques for communicating with older adults with specific approaches to those with sensory losses and dementia.

With the explosive growth of the older population, clinical encounters such as the one just described will become increasingly common in primary care offices. The number of Americans aged 65 and older is predicted to reach 40 million by 2010 and to rise to more than 55 million by 2020 [1]. The greatest increase will occur in those aged 85 and older, the segment of the population most affected by dementia [1,2]. Physicians entering practice need to understand the unique needs of the elderly population so they are better prepared to communicate effectively during visits with older patients.

It is well documented that good communication

with patients is key to successful clinical encounters, doctor-patient relationships, and health care outcomes. However, this essential ingredient of patient care is complex and takes skill and practice. To some degree, the skills are the same regardless of the patient involved. Successful communication requires an effective approach to the patient at hand, the ability to listen and allow the patient to tell his or her story, and adept investigation to clarify and fill in essential information.

Communication with older adult patients can be made more challenging as a result of age-related sensory impairment and memory decline. In addition, a third person may be part of the interaction, as elderly patients often are accompanied by a family member or loved one who is actively involved in the patient's care and participates in the visit. Other factors impacting effective communication with older patients are numerous. Older adults often present with complex problems and several chief complaints, which require time to unravel. For every decade of life after age 40, patients are likely to have 1 new chronic disease [3]. Thus, an 80-year-old person is likely to have at least 4 chronic illnesses. Another factor is that older patients generally ask fewer questions and are more likely to defer to the physician's authority [4,5]. In addition, ageism is prevalent in health care and may unintentionally contribute to poor communication with elders [6,7]. Doctors spend less time on psychosocial issues, and older patients are less likely to raise these concerns [4]. Finally, despite the complexity of their problems, older patients receive less health education and counseling than younger patients [4].

This article offers practical tips to help physicians optimize the time spent during outpatient visits with older patients. General techniques to enhance communication with older patients are presented as well as specific strategies to aid communication with patients who have sensory or cognitive losses or who are accompanied by family members or other caregivers (Table).

General Techniques for Communicating with Older Patients

Establish Respect and Demonstrate Concern

Good patient communication is based on respect for the patient and an understanding and appreciation of

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Table. Tips for Effective Communication with Older Patients in the Outpatient Setting

General strategies

- Prepare the environment of the examination room, increasing the lighting and decreasing background noise (considering the probability of vision or hearing loss)
- Address the patient and family member as “Mr.” or “Mrs.” and avoid terms such as “sweetie,” “honey,” or “dear”
- Speak slowly, clearly, without shouting, using a calm tone and pleasant expression
- Use gentle touch with a light touch to the hand, arm, or shoulder
- Maintain an unhurried pace, allowing the patient a few minutes to express his/her concerns if able
- Ensure it is the patient’s agenda you are addressing
- Ask the elder to repeat back any important instructions
- Provide written instructions in at least 14-point type
- Remember the importance of psychosocial issues when caring for older patients

Cognitively impaired patients

- Do not ignore the patient
- Ask questions simply, using “yes” or “no” questions and simple gestures
- When performing the examination, give one instruction at a time

Encounters with third party involvement

- Prepare the environment of the examination room by setting 3 chairs in a triangle
- Direct questions initially to the patient, *then* ask for input from the patient’s companion
- Ask the patient *and* the patient’s companion to repeat back any important instructions

each patient as a unique human being. To demonstrate respect, you should address the patient formally as “Mr.” or “Mrs.,” unless the patient has previously asked you to use first names, and avoid using patronizing terms such as “sweetie,” “honey,” or “dear” [8]. Communicate at eye level by sitting in a chair and directly facing the patient [8]. By doing so, you demonstrate genuine interest and active listening, as well as help the patient to better hear and understand you. A gentle touch on the patient’s hand, arm, or shoulder conveys concern and interest [8].

Ensure the Patient Is Heard and Understands

Maintaining an unhurried pace and listening are key to effective older patient–physician communication

[8,9]. Allowing older patients a few minutes to talk about their concerns without interruption will provide more information than a rapid-fire structured history [8]. Feelings of being rushed will cause older adults to feel that they are not being heard or understood [8,9]. Studies have shown that older patients and physicians often disagree about the goals of the medical encounter [5]. Poor communication can impair exchange of information as well as decrease patient satisfaction [5].

In general, you should speak slowly, clearly, and loudly without shouting, using short simple words and sentences [8,10]. As older patients generally ask fewer questions and defer to the physician’s authority [4,5], it is especially important to summarize frequently and invite questions [10]. Additional general strategies for improving communication with older adults include [8,10]:

- Gather preliminary data before the appointment, as older patients typically have complex and multiple health issues
- Have patients tell their story only once (ie, not to a nurse or assistant first and then to you) to minimize patient frustration and fatigue
- Avoid medical jargon
- Simplify and write down instructions
- Use charts, models, and pictures
- Schedule older patients earlier in the day, as they are generally more alert and clinics tend to be less busy

Avoid Ageism

One of the most important things to remember when communicating with older adults is to avoid ageism. Ageism, a term first coined by Robert Butler, the first director of the National Institute on Aging, is the systematic stereotyping of and discrimination against people because they are old [6]. Ageism is prevalent in health care and may be reflected in such actions as trivializing medical problems, using condescending language, providing less education on preventive regimens, offering little treatment for mental health issues, using derogatory names, spending less time on psychosocial issues, and stereotyping elders [7]. To avoid ageism, get to know the older patient as a person with a defined history and accomplishments. This approach enables you to see each older patient as a unique individual with a lifetime of valuable experiences rather than an unproductive, frail old person [11]. It is also

important to not assume that all older patients are the same. There can be “young” 85 year olds as well as “old” 65 year olds. Each patient and each encounter should be treated uniquely.

The Patient with Sensory Deficits

Few adults escape age-related visual and hearing deficits, both of which will require adaptations in communication. Studies indicate that 16% to 24% of individuals over age 65 have hearing loss that interferes with communication [12,13]. For those over 80, the number rises to more than 60% [14]. Aging results in auditory functional decline known as *presbycusis*, which particularly affects high-frequency sounds. These are the consonant sounds that impact the patient’s understanding of the beginning and end of words. For example, if you say “Take the pill in the morning,” the patient will hear the vowels in the words but may think you said “Rake the hill in the morning” [15–18].

Age-associated visual deficits include reduction in pupil diameter; yellowing of the lens, which makes it difficult to distinguish short wave lengths such as lavenders, blues, and greens; and a decrease in elasticity of the ciliary muscles, which results in decreased accommodation when printed material is held at various distances. Additionally, many elders have eye diseases that lessen visual acuity (eg, cataracts, macular degeneration, glaucoma, ocular complications of diabetes). More than 15% of adults over age 70 reported their vision as poor, and an additional 22% reported their vision as only fair [13]. For those over age 80, 30% reported vision as impaired [14].

Approach to Communication

When communicating with an older adult with hearing loss, face the patient so he or she can lip read and pick up visual cues. Minimize background noise, and speak slowly, clearly, and in a normal tone [8]. Shouting hampers communication, distorting high-frequency tones and making it more difficult for the patient to understand your words [8]. If your voice is high pitched, deepening the pitch when you speak can help the patient hear you better [8]. When giving instructions for medications, tests, or treatments, avoid asking the patient if he or she understands. Hearing-impaired people will likely answer “yes,” not realizing that they have not heard everything or have misunderstood some of the information. A better approach to checking the patient’s understanding is to ask the patient to repeat the instructions [8]. Finally, because hearing worsens later in the day, early appointments are generally better [17]. If available, a voice amplifier

(a small, portable device that amplifies the physician’s voice and transmits it into headphones worn by the patient) has been shown to greatly facilitate communication with hearing-impaired patients [16].

When communicating with visually impaired patients, the environment of the clinic can be enhanced by improving illumination, using contrasting colors to make objects stand out (eg, door frames around doors, chairs against the clinic floor), and using large letters and contrasting colors in any signs [11]. Two sources of light, background lighting and a close light, are recommended [11]. Any written material should be printed in at least 14-point type on buff-colored paper [8,11]. When discussing treatment plans, keep in mind the potential safety issues of vision impairment. For example, older patients sometimes will put their medications in one container and depend on color recognition to identify them. This can be a safety issue, as many medications are white, pale blue, or pale green, which will appear gray to the aging eye. The colors of red, orange, and yellow are seen best and can be incorporated into care. In another example, a patient who is having difficulty drawing up insulin might be instructed to place a red placemat on the table, which will make it easier to see the syringe and vial. Similarly, red contact paper can be wrapped around the handles of a walker, a cane, or oxygen tubing to help an older patient locate these important items [8].

The Patient with Dementia

As of 2008, approximately 5.2 million persons in the United States had some form of dementia, and this number is predicted to double over the next 30 years [2]. As a result, physicians can expect to see more patients with dementia and to have these patients come in for visits accompanied by family members or other informal caregivers [3]. (Note that the term *caregiver* is used from this point to refer to any visit companion who is an informal caregiver.) Assessment and treatment of older patients with dementia will need to include consideration of the caregiver as well [11,19].

There are many levels of dementia, which pose a variety of communication difficulties. Patients in mild stages often experience subtle word-finding problems. As dementia progresses, patients use a high proportion of nonmeaningful words, such as “these,” “things,” and “you know.” In severe dementia, patients may use unintelligible jargon or may be mute [20]. Dementia adversely affects patients’ receptive and expressive communication. Most patients have memory loss with some difficulty with recall of recent

events. Some will have very short concentration spans and find it difficult to stay on a particular topic [21].

Approach to Communication

The most critical factor in communicating with the patient with dementia is to establish a caring relationship as soon as possible. Of utmost importance is to treat the person with dignity and respect. There is a tendency to infantilize patients with dementia or to speak to them as if they are children. It must be remembered that patients with dementia are losing their ability to communicate, not their intelligence. They are adults who have lived productive lives and deserve respect. In addition, patients with dementia are very sensitive to others' emotions. In general, these patients respond more to how someone talks to them rather than what is actually said [21–23]. Consequently, it is critical to approach these patients in a calm, pleasant manner. Patients with dementia rely heavily on nonverbal communication, so it is important not to allow body language to give the impression that you are in a hurry [20,22,23].

Upon entering the examination room, you should approach the patient directly and slowly, making eye contact and exhibiting a pleasant expression. A calm tone of voice and a gentle touch on the arm or shoulder will usually convey concern and caring. You should reintroduce yourself, even if you have known the patient for many years. It is often effective to begin the interview socially and to spend a few minutes chatting or reminiscing with the patient. Reminiscing is a more effective communication technique with a patient with dementia because long-term memory is often retained. For example, you might ask simple questions about the patient's past and then listen closely. Reminiscing helps to overlap the past, present, and future time spheres and helps reduce stress [22,24].

Questions should be asked simply and slowly [22]. Jargon and use of figurative terms should be avoided, as patients will interpret these statements literally [22]. For example, when asking a patient to describe epigastric pain, you should avoid asking if it is a "burning" pain. Simple physical gestures can be helpful. You can place your hand over your chest and move it up and down. Sometimes closed-ended ("yes" and "no") questions may work best [21,22]. Wait 15 to 20 seconds before repeating the question, using the same words [22]. Routinely quizzing with orientation questions will likely cause frustration. Patients with dementia cannot answer these questions because of memory loss [22,23]. Listening closely to patients with dementia is critical. Although you may

not understand everything, a few words in the conversation may provide an idea of what the patient is attempting to convey. Caregivers often can decipher bizarre or out of place words that are grounded in the patient's past experiences [22,23].

When performing the physical examination, it is preferable to give one instruction at a time [22]. For example, if you want to examine the patient's gait, it is best not to say, "Please stand up, walk across the room, and walk back." It would be better to begin by saying, "Please stand up." Then, after the patient has accomplished this task, proceed with, "Please walk across the room." Patients with dementia can easily misinterpret touching of the body during the physical examination. It is important to convey respect and ask permission with each step of the examination. For example, "May I listen to your chest?" (and show the stethoscope), "May I check your abdomen?" (and then examine the abdomen), and so on [22].

The Patient Who Is Accompanied by a Caregiver

A major characteristic of the geriatric clinic visit is the presence of a third person, with a family member or other informal caregiver present in at least one third of geriatric visits [11]. Although caregivers can assume a variety of roles, including advocate, passive participant, or antagonist, in most cases they have their loved one's health as the priority. Caregivers are critical to the health care system. Not only do they assist with nutrition, activities of daily living, household chores, medication administration, transportation, and other care for older adult patients, they help to facilitate communication between the physician and patient and improve patient involvement in their own care [25,26]. It is essential to treat older patients in the context of their caregiver(s) to attain the best outcomes for both [8,27].

Approach to Communication

At the first visit, in order to protect the patient's privacy, it is best to see the patient alone and to ask the patient's permission to speak to the caregiver alone [28]. In subsequent visits, if agreeable to the patient, the caregiver can join the patient during the appointment [28]. When a caregiver is present during the clinic visit, the communication becomes a 3-way interaction. To facilitate communication, you should arrange chairs so that the 3 of you are sitting in a triangle. Then, you can pose questions to the patient and then ask for input from the caregiver. Caregivers can clarify older patients' concerns and reinforce any

instructions that are provided to patients. Importantly, you need to involve the patient in the encounter, even if a caregiver interjects by answering questions. Patients are frequently excluded or minimized during visits in which a third person is present, so it is important that you always try to fully involve the patient in all decisions [8,29].

The doctor-patient-caregiver relationship is dynamic, changing over time as patient and caregiver needs change. Caregivers can provide descriptions of symptoms, changes in functioning, and assessments of medication effects. Since the caregiver is integral to the patient's care, it is important to be alert for verbal and nonverbal signs of physical or emotional stress of the caregiver [28]. Caregivers' perceptions of patients' ability to perform activities of daily living are highly correlated with caregivers' level of distress [30]. Thus, you should ask questions that elicit descriptions of the patient's level of functioning and observe for signs of stress or depression in the caregiver. Praise for the caregiver provides encouragement to both patient and caregiver [30].

Return to the Scenario

To illustrate how these communication strategies might be used during a clinic visit, we return to the opening scenario. In integrating the communication techniques into the clinic appointment with Mr. and Mrs. Howell, consideration must be given to the presence of a third person, the elderly status of both individuals, hearing and visual deficits of the patient, and the patient's dementia.

You have a good established relationship with Mr. and Mrs. Howell and previously obtained permission from Mr. Howell for Mrs. Howell to participate in appointments. You also have ensured that there are 3 chairs in the exam room. Upon entering the room, you find Mr. and Mrs. Howell sitting in 2 of the chairs. You position the third chair so that you are all sitting in a triangle, with Mr. and Mrs. Howell within 2 ft from you so they can see and hear you well.

You reintroduce yourself, realizing that Mr. Howell may not remember your name. "Hi, Mr. and Mrs. Howell," you say, speaking slowly and clearly as you reach out your hand to shake both their hands. "I am Dr. Smith. It is good to see you again."

You socialize a bit to engage Mr. and Mrs. Howell in the visit. Looking directly at Mr. Howell you say, "I notice that you just had a birthday, Mr. Howell. Did you have a special celebration?"

You notice that Mr. Howell is having some dif-

ficulty with word finding. After a brief discussion of his recent party, you redirect the discussion to the chief complaint of "stomach pain." Again, looking directly at Mr. Howell, you say, "I understand that you have been having some stomach pain. Please show me where it hurts."

After Mr. Howell points to his epigastric region, you ask him to describe the pain. He has trouble finding words, so you switch to closed-ended questions.

"Is it a severe or mild pain?" "Does the pain move up and down in your chest?" "Is the pain worse after meals?"

You listen closely and think that Mr. Howell may have GERD. Next, you ask him if he has heartburn. He nods in agreement. Finally, you inquire about weight loss, dysphagia, and melena to rule out more severe causes of epigastric pain. Then you turn to Mrs. Howell for her to add any additional information. You feel fairly confident in a diagnosis of GERD and decide to do a trial of omeprazole.

Looking directly at Mr. Howell, you say, "Mr. Howell, I believe your stomach pain could be due to too much acid in your stomach. The problem is called 'GERD,' and it is very common. I would like to try a medication that stops the excess acid. OK?"

"OK," Mr. Howell replies.

You then explain to Mr. and Mrs. Howell how the medication should be taken. You ask them to repeat back the instructions to you, which they do without error. You also provide a patient education pamphlet, "*Practical Tips for Reducing the Symptoms of GERD*," which is printed in large type on buff-colored paper.

You then ask both Mr. and Mrs. Howell about additional concerns and learn that Mr. Howell is having more difficulty with walking, dressing, and bathing. Mrs. Howell is helping him get up and down from chairs now. You compliment both of them on the great job that they have done over the years. Kindly and gently, you suggest that some outside assistance might be very helpful to them, such as a home health agency.

"I think I might be able to help make life a bit easier for you. There is a local agency that specializes in providing home assistance. For example, an occupational therapist could make some suggestions and provide equipment that might make dressing and grooming a little easier. Also, Mrs. Howell, a physical therapist could show you how to help Mr. Howell get out of bed and the bathtub more easily."

Mr. and Mrs. Howell are both agreeable to your proposed plan.

"Good," you say. "My nurse will call the agency and then call you with the details."

Before you leave the room, you review the care plan with both of them and ask Mrs. Howell to repeat back her understanding of how to use the new medication and the plan to involve the home health agency.

She replies, "I should give the new medicine in the morning before breakfast and in the evening before dinner. Your nurse will contact the home health agency, which will help us out with things at home and then she will let me know when they will come visit."

"Yes, exactly. Very good. Now, do either of you have any questions, or is there anything else you want to tell me?"

Mr. and Mrs. Howell both shake their heads. "No," says Mrs. Howell. "Thank you, doctor. I'm relieved that the stomach pain probably isn't serious."

"No, I really think this is just too much stomach acid. But let me know if the medication does not help. Thank you both for coming. I hope that the changes we made today will make life a bit easier for you. Again, my nurse will be in touch soon. Good bye."

Conclusion

The ultimate benefit of applying these communication techniques will be improvement in outcomes for older patients and their caregivers. Evidence indicates that outcomes of health care for older adults are dependent not only on care of biomedical needs but also on the caring relationship created through effective communication [31]. With effective physician–older patient communication, patients are:

- More likely to share their symptoms and concerns, which will enable the physician to make a more accurate diagnosis [32];
- More likely to follow through with physician recommendations [33];
- Less likely to skip doses or stop a medication because of side effects, perceived nonefficacy, or drug cost [33,34]; and
- More likely to self-manage diabetes with diet, exercise, blood glucose monitoring, and foot care [35].

Decreases in diagnostic testing costs have also been associated with better physician–older patient communication [34]. Ultimately, the interview itself can be therapeutic for the older patient. The physician–

older patient relationship goes far beyond medical care and, like all successful relationships, is based in closeness and trust. Open and frequent communication between the physician and older patient is the most important element in this relationship [11,31].

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References

1. Administration on Aging and American Association of Retired Persons. A Profile of older Americans. Available at www.aoa.gov/PROF/statistics/profile/profiles.asp. Accessed 11 Jul 2008.
2. Alzheimer's Association. 2008 Alzheimer's disease facts and figures. Available at www.alz.org/national/documents/report_alzfactsfigures2008.pdf. Accessed 23 Dec 2008.
3. Vieder JN, Krafchick MA, Kovach AC, Galluzzi KE. Physician patient interaction: what do elders want? *J Am Osteopath Assoc* 2002;102:73–8.
4. Haug MR, Ory MG. Issues in elderly patient-provider interactions. *Res Aging* 1987;9:3–44.
5. Greene MG, Adelman RD, Charon R, Friedmann E. Concordance between physicians and their older and younger patients in the primary care medical encounter. *Gerontologist* 1989;29:808–13.
6. Butler RN. Age-ism: another form of bigotry. *Gerontologist* 1969;9:243–6.
7. Ory M, Kinney Hoffman M, Hawkins M, et al. Challenging aging stereotypes: strategies for creating a more active society. *Am J Prev Med* 2003;25(3 Suppl 2):164–71.
8. Adelman RD, Greene MG, Ory MG. Communication between older patients and their physicians. *Clin Geriatr Med* 2000;16:1–24, vii.
9. Working with your older patient: a clinician's handbook. Bethesda (MD): National Institute on Aging; 2004. NIH Publication No. 04-7187.
10. Robinson TE 2nd, White GL Jr, Houchins JC. Improving communication with older patients: tips from the literature. *Fam Pract Manag* 2006;13:73–8.
11. Roter DL. The outpatient medical encounter and elderly patients. *Clin Geriatr Med* 2000;16:95–107.
12. Mitchell RE. How many deaf people are there in the United States? Estimates from the Survey of Income and Program Participation. *J Deaf Stud Deaf Educ* 2006;11:112–9.
13. Crews JE, Campbell VA. Vision impairment and hearing loss among community-dwelling older Americans: implications for health and functioning. *Am J Public Health* 2004;94:823–9.
14. Chia EM, Mitchell P, Rochtchina E, et al. Association between vision and hearing impairments and their combined effects on quality of life. *Arch Ophthalmol* 2006;124:1465–70.
15. Fook L, Morgan R. Hearing impairment in older people: a review. *Postgrad Med J* 2000;76:357–41.
16. Fook L, Morgan R, Sharma P, et al. The impact of hearing on communication. *Postgrad Med J* 2000;76:92–5.
17. Veras RP, Mattos LC. Audiology and aging: literature review and current horizons. *Braz J Otorhinolaryngol* 2007;73:122–8.
18. Ross B, Fujioka T, Tremblay KL, Picton TW. Aging in binaural hearing begins in mid-life: evidence from cortical auditory-evoked responses to changes in interaural phase. *J Neurosci* 2007;27:11172–8.
19. National Alliance for Caregiving and AARP. Caregiving in the U.S. Available at www.caregiving.org/data/04finalreport.pdf. Accessed 16 Jan 2009.
20. Orange JB, Ryan EB. Alzheimer's disease and other dementias. Implications for physician communication. *Clin Geriatr Med* 2000;16:15–73, xi.
21. Miller CA. Communication difficulties in hospitalized older adults with dementia. *Am J Nurs* 2008;108:58–66; quiz 67.
22. Alzheimer's Association. Communication: best ways to interact with

- the person with dementia 2005. Available at www.alz.org/national/documents/brochure_communication.pdf. Accessed 26 Jan 2009.
23. Smith M, Hall GR, Gerdner L, Buckwalter KC. Application of the Progressively Lowered Stress Threshold Model across the continuum of care. *Nurs Clin North Am* 2006;41:57–81, vi.
 24. Puentes WJ. Incorporating simple reminiscence techniques into acute care nursing practice. *J Gerontol Nurs* 1998;24:14–20.
 25. Wolff JL, Roter DL. Hidden in plain sight: medical visit companions as a resource for vulnerable adults. *Arch Intern Med* 2008;168:1409–15.
 26. Clayman ML, Roter D, Wissow LS, Bandeen-Roche K. Autonomy-related behaviors of patient companions and their effects on decision-making in geriatric primary care visits. *Soc Sci Med* 2005;60:1583–91.
 27. Griffith JC, Brosnan M, Lacey K, et al. Family meetings—a qualitative exploration of improving care planning with older people and their families. *Age Ageing* 2004;33:577–81.
 28. Silliman RA. Caregiving issues in the geriatric medical encounter. *Clin Geriatr Med* 2000;16:51–60.
 29. Greene MG, Majerovitz SD, Adelman RD, Rizzo C. The effects of the presence of a third person on the physician-older patient medical interview. *J Am Geriatr Soc* 1994;42:413–9.
 30. Razani J, Kakos B, Orieta-Barbalace C, et al. Predicting caregiver burden from daily functional abilities of patients with mild dementia. *J Am Geriatr Soc* 2007;55:1415–20.
 31. Williams SL, Haskard KB, DiMatteo MR. The therapeutic effects of the physician-older patient relationship: effective communication with vulnerable older patients. *Clin Interv Aging* 2007;2:453–67.
 32. Larson EB, Yao X. Clinical empathy as emotional labor in the patient-physician relationship. *JAMA* 2005;293:1100–6.
 33. Stewart M, Meredith L, Brown JB, Galajda J. The influence of older patient-physician communication on health and health-related outcomes. *Clin Geriatr Med* 2000;16:25–36, vii–viii.
 34. Wilson IB, Schoen C, Neuman P, et al. Physician-patient communication about prescription medication nonadherence: a 50-state study of America's seniors. *J Gen Intern Med* 2007;22:6–12.
 35. Heisler M, Cole I, Weir D, et al. Does physician communication influence older patients' diabetes self-management and glycemic control? Results from the Health and Retirement Study (HRS). *J Gerontol A Biol Sci Med Sci* 2007;62:1435–42.

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