



# M A G E C

## M E S S E N G E R

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by Gwen Yeo, Ph.D.

Health care providers frequently hear that the U.S. is facing a “geriatric imperative”. Television and magazines are filled with phrases such as the “aging of the baby boomers” and the “graying of America”. The Institute of Medicine and other prestigious organizations have documented the dramatic under supply of physicians and other health care providers trained in geriatrics who will be needed to care for the exploding population of older adults in the U.S. beginning in 2020. What we don’t hear as much about is the increasing ethnic and cultural diversity within this projected enormous bulge in our population pyramid. The truth is that there is not only a geriatric imperative facing us, but also an **ethnogeriatric** imperative.

The numbers of elders in the categories who are classified as ethnic minority are growing dramatically, but probably more importantly, the diversity **within** the categories is multiplying rapidly. In order to provide even adequate, if not, excellent care, it is essential that consideration be given to how our health care institutions should prepare for this ethnogeriatric imperative.

The projected growth of older Americans in populations defined as “minority” by the federal government (including African American, Hispanic or Latino, American Indian and Alaska Native, and Asian and Pacific Islanders) increased from 13 to 16 percent of all older Americans from 1990 to 2000, and each of the populations is projected to grow more rapidly than the non-Hispanic white population of older Americans throughout the next half century. By 2025, elders from those categories are

projected to comprise one in four older Americans, and by mid century, one in three of the 82 million elders in the U.S. are expected to be from a “minority” population. Although these are the “minority” category data that are most widely available, they vastly under-represent the heterogeneity that our health care providers will be facing. Within each of the categories used by the census as “minority” are many diverse cultural groups, very evident in the most rapidly growing categories, the Hispanic/Latino and the Asian. Elders classified as Hispanic/Latino can be of any “race” according to the census categories and are expected to be 16% of all Americans aged 65 and over by 2050. Although they generally have in common their first language of Spanish or ancestors who spoke Spanish, they may be from Mexico, Puerto Rico, Cuba, or other Caribbean Islands, or Central or South America, or Spain. They may have come to the U.S. in the last month, or their ancestors may have come to what was New Spain in the 16<sup>th</sup> century, or any time between. Asian American elders are even more diverse since they have no common language. Their countries of origin include over 30 nations (each of which may be very diverse itself) spanning over half the globe, each with very distinct histories, religions, approaches to health and health care, and cultural traditions. Diversity is also vast within the categories of African American and American Indians/Alaska Natives, the latter of which includes over 500 different tribes, each with its own language, history, and culture.

This heterogeneity within the “minority” categories does not even take into account the vast diversity

within the Non-Hispanic White category that is usually considered the “majority” population. Cultural differences originating in the major periods of heavy immigration from Southern and Eastern Europe in the early 1900s still exist in some neighborhoods. Populations who have come to the U.S. more recently from the Middle East provide a rich and complex variety of cultures and religions in many communities. The same is true of recent immigrants from Russia and other Eastern European countries formerly in the Soviet Union, all of whom would be lumped into the demographic category labeled “non-Hispanic White”.

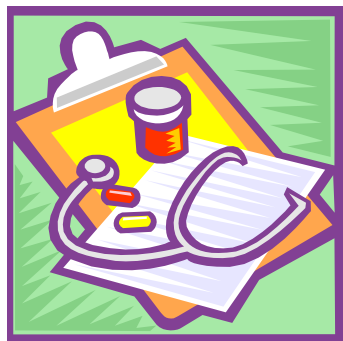
One of the most influential dimensions of variability in geriatric care involves the degree of acculturation to the American society and Western health care. It is very important for providers to recognize that any elder, even though a recent immigrant, may have values and attitudes that resemble mainstream American elders.

So, what difference does it make that health care providers are likely to be seeing an increasingly diverse geriatric patient population? Core Faculty of the Stanford Geriatric Education Center that specialize in Ethnogeriatrics have a saying, “Celebrate the Diversity and Appreciate the Complexity”, recognizing that with all the richness and excitement that a culturally heterogeneous society brings comes frequently complex cross-cultural interactions, especially in health care.



### *The Ethnogeriatric Imperative*

## Help Yourself to a “Continuing Education P.I.L.L.”



This two-page session provides information to all health care professionals including physicians, nurses, social workers, psychologists, and others involved in direct patient care. Please familiarize yourself with the following “lessons learned” and pass the information to others.

The Patient Initiated Lessons Learned (P.I.L.L.) study was conducted during the time period of September 2000 – September 2002, IRB protocol # 00/313C. The study proposed to examine whether providing education to health care professionals on topics selected by their geriatric patients improves patient satisfaction.

The study consisted of confidential one-on-one oral interviews with cancer patients and their caregivers, both 60 + years of age. Following consent, participants were asked to complete demographic questions, a satisfaction survey, and to answer a series of open ended questions relating to the care and treatment received, past and present, from their health care providers.

Following the study and assimilation of material, a literature review has been completed. This information is supplemented from lessons learned by the Principal Investigator during her two decades of clinical experience.

Our intent is to illuminate specific issues, comprised of two major categories, raised by study participants. These are followed by a list of benefits that you, as a professional, can expect to gain by understanding and attending to these issues. Lastly, we offer selected excerpts from a major researcher in the field of health psychology, Dr. Shelley Taylor, whom supports our findings and anticipated outcomes.

The Miami Area Geriatric Education Center (MAGEC), currently funded by the Bureau of Health Professions (BHPr), completed this research study with Avis M. Bernstein, Ph.D. as Principal Investigator and Drace Langford, M.S.G. as Assistant.

We welcome any comments, requests and/or questions you may have. You may reach us at 305.243.6270 or via email [magec@med.miami.edu](mailto:magec@med.miami.edu). We will be posting this information on the web at [www.miami.edu/magec](http://www.miami.edu/magec).

### Recommended “Do’s” and “Don’ts”

#### *Issues Raised By Participants And The Importance Of Communication*

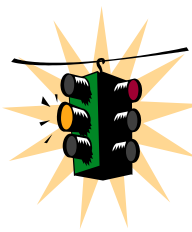
##### “Do’s”

- Be sensitive to patient limitations that may affect communication e.g., impaired hearing, memory
- Listen actively (not being heard or listened to was a common complaint)
  - Attend to and encourage patient’s questions
  - Position yourself at eye level with patient; maintain eye contact, mirror patient
  - Attend to non-verbal cues – given and received – e.g., tone and volume of voice, facial expressions, posture and gestures
- Be ‘fully present’ to attend to patient needs
  - To enhance one’s ability to be ‘fully present’, individual practice of meditation for the professional is highly recommended
- Encourage patient responsibility – be ‘proactive’ versus ‘reactive’
  - Foster an atmosphere of cooperation as patients play an active role in decision-making – make efforts to achieve “*concordance between patient and provider*”
  - Encourage health behaviors and efforts towards prevention
- Enhance empathy and sensitivity by creating rapport – a trusting relationship
  - Provide feedback where appropriate, being sensitive to patient’s needs
  - Balance a *professional* with a *caring* demeanor



## Help Yourself to a “Continuing Education P.I.L.L.” - Continued

### “Don’ts”



- Use medical jargon that serves to:
  - Confuse the patient
  - Distance patient from professional
  - Exaggerate power imbalance in which patient feels intimidated
- Depersonalize care by being unaware of patients’ name or presenting complaint
- Infantilize patient – most noticeable in working with older patients - reveals disrespect
- Communicate negative expectations

### Importance of Social Support

Social support has been revealed as a significant ‘buffer’ in both reducing the negative impact of illness and preventing disease. Professionals can enhance the benefits of social support by being sensitive to the patients’ support network -composed of family and friends – without over-stepping patient confidentiality.

Be sensitive to patients’ background including ethnicity, prior life and experiences. Facilitate and foster social support by providing patient-to-patient contact, where appropriate.

### Benefits

- Improved patient compliance
- Decreased malpractice litigation
- Enhanced placebo effect
- Improved perception of professional’s competency
- Effective communication between patient and provider improves treatment outcome and reduces risk of significant medical complaints by earlier reporting of symptoms – enhancing proactive care

### Excerpts from *Health Psychology* by Shelley Taylor

- “...criticisms of providers usually center on volumes of jargon, little feedback, and depersonalized care. Patients increasing desire and need to be involved in decisions affecting their health...” (Taylor, 1999)
- “...providers contribute to poor communication by not listening, by using jargon-filled explanations and infantilizing baby talk, by communicating negative mood or expectations, and by depersonalizing the patient...” (Taylor, 1999)
- “...communication affects not only adherence with treatment and malpractice litigation – by taking full advantage of the providers potent professional role, can serve to enhance placebo effect revealed to exist in virtually every medical treatment.” (Taylor, 1999)
- “Clearly, the quality of communication with a provider is important to patients, but does good communication do anything more than produce a vague sense of satisfaction or dissatisfaction in the patients mind? The answer is yes. Poor patient-provider communication has been tied to outcomes as problematic as patient noncompliance with treatment recommendations and the initiation of malpractice litigation... additionally technical quality is often judged by the manner in which it is delivered.” (Taylor, 1999)

### Bibliography:

- ❖ Taylor, Shelley E., (1999). *Health Psychology, Fourth Edition*. McGraw-Hill.
- ❖ Cole DC. Mondloch MV. Hogg-Johnson S., 2002 Mar 19, *Listening to injured workers: how recovery expectations predict outcomes—a prospective study*. Canadian Medical Association Journal, 166(6): 749-54.
- ❖ Sarason, B. R., Sarason, I. G., & Gurung, R. A. R. (1997). Close personal relationships and health outcomes: A key to the role of social support. In S. Duck (Ed.), *Handbook of Personal Relationships* (pp. 547-573). New York: Wiley.



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## CALENDAR OF CME/CEU EVENTS

**Mark Your 2004 Calendar! Contact MAGEC for more information at (305) 243-6270**

### May 21, 2004

*Focus on Caregiving*  
 CME/CEU hours: 5 hours for nursing home administration, social work, physical therapy, and occupational therapy.  
 Location: Mount Sinai/Miami Heart Institute, 4701 N. Meridan Avenue, Miami Beach, FL  
 Call (305) 674-2018 or (305) 243-4082 for additional information.

### May 26-28, 2004

*Intensive Geriatric Training: Psychology Module*  
 CME/CEU hours: 20 hours pending for FL psychologists.  
 Location: Diabetes Research Institute 1450 NW 10th Avenue, Miami, FL.  
 Call (305) 243-6270 for additional information.

### June 23-25, 2004

*2004 Intensive Geriatric Training*  
 CME/CEU hours: 20 for medicine, nursing, psychology, social work, physical therapy, occupational therapy, and nutrition.  
 Location: The Westin, 400 Corporate Drive, Ft. Lauderdale, FL.  
 Call (305) 243-6270 for additional information.

### August 30 - September 2, 2004

*The Florida Conference on Aging 2004: Aging: It's BOOMing!*  
 Location: The Hotel InterContinental, Downtown Miami, FL.  
 For more information, visit <http://www.fcoa.org/Conf2004/conf2004.html>, e-mail [conference@fcoa.org](mailto:conference@fcoa.org), or call (850) 222-8877.

### October 14-15, 2004

*MAGEC Ethnogeriatric Conference*  
 CME/CEU hours: TBA  
 Location: TBA  
 Call (305) 243-6270 for additional information.



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[www.miami.edu/magec](http://www.miami.edu/magec)

## CE PROGRAM DESCRIPTION

### 2004 Intensive Geriatric Training June 23-25, 2004 The Westin Fort Lauderdale

The Intensive Geriatric Training (IGT) is a 40-hour comprehensive geriatric training program for health care providers and practitioners from 15 different health disciplines.

The multidisciplinary portion of the program is 20 hours in length and is offered in a 3-day intensive format. This year's IGT conference will be held on June 23-25, 2004 at the Westin hotel located at 400 Corporate Drive,

Fort Lauderdale, FL 33334. Through didactic presentations, concurrent sessions, and group activities, the program offers participants an opportunity to interact and learn from professionals representing a variety of health and mental health disciplines.

The discipline specific sessions (Part B) are schedule from July 2004 through May 2005 following the multidiscipline sessions. These sessions will be held in various classrooms and clinical sites at the University of Miami/Jackson Memorial Hospital medical campus, MAGEC affiliates, and community health care facilities.

MAGEC offers discipline specific sessions in the following areas:

- ☉Medicine
- ☉Nursing
- ☉Nutrition
- ☉Occupational Therapy
- ☉Pharmacy
- ☉Physical Therapy
- ☉Podiatric Medicine
- ☉Psychology
- ☉Social Work

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