Power Relations and Health Care Communication in Older Adulthood: Educating Recipients and Providers

A. Henry Eliassen, PhD
Forum

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A. Henry Eliassen, PhD

Department of Social Sciences, University of Houston–Downtown, Texas.

Address correspondence to A. Henry Eliassen, PhD, Department of Social Sciences, University of Houston–Downtown, One Main Street, N1067, Houston, TX 77002-1014. E-mail: eliassena@uhd.edu

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Abstract

Unequal power relations lie just below the surface in much of today’s discourse on health care communication with older adults. Focusing on pathologies or deficits tends to reinforce stereotypes of frailty and dependency, thus framing elders as a vulnerable group requiring special assistance. Implicit stereotyping frequently colors interactions of health care personnel with older clients and their families—interactions likely to affect elders’ perceptions and health outcomes. Health care providers need to be attuned to the vast and growing diversity in today’s older population, wherein many older adults are exemplars of what it takes to marshal resources and cope with multifaceted challenges. Thus, elders have the potential to teach medical personnel through narratives of resilience as well as tribulation. This potential can be fully realized, however, only in contexts where communication patterns characterized by paternalism, consumerism, and collaboration are mutually recognized and selectively challenged or implemented. Promising interventions to facilitate health care communication in older adulthood might well be directed toward (a) educating both recipients and providers to become more mindful of cues that evoke stereotypical thinking, (b) promoting an institutional culture that normalizes situationally appropriate assertive responses to stereotyping, and (c) formally ratifying older adults’ life experience in the training of health care personnel.

Keywords: Ageist stereotyping, Health care collaboration, Health care consumerism, Medical paternalism, Patient–provider relationship

With the rapid aging of the U.S. population in the early 21st century—at a rate of around 10,000 baby boomers reaching the age of 65 years each day (Pruchno, 2012)—an ever-increasing share of occasions for communication between health care recipients and providers will involve older adults. As of 2010, individuals aged 65 and older accounted for around 25.7% of U.S. physician office visits (National Center for Health Statistics, 2013). That proportion will rise accordingly as the 65-and-over component grows from 13.0% in 2010 to a projected 19.3% of the total population by 2030 (Vincent & Velkoff, 2010).

In this context, it is incumbent upon all parties to be cognizant of the intrinsically unequal, yet continually shifting, power relations that routinely underlie health communications (Goodyear-Smith & Buetow, 2001). At any given moment in any given situation, the prevailing balance of power can be understood as localized and potentially subject to challenge (Foucault, 1978/1990, pp. 92–102), depending upon the actors, roles (whether agreed upon or not), and setting involved. In this regard, health service providers need to be keenly aware of the vast diversity in today’s older population—diversity not only in health status but also in background, life experience, and expectations (Pruchno, 2012). Doctors, nurses, and other personnel may find it necessary to cultivate insight into ways in which their own assumptions and implicit stereotypes may be affecting interactions with seniors under their care—interactions certain to affect elders’ perceptions and health outcomes (Allen, 2015; Chettih, 2012; Ryan, Anas, & Friedman, 2006).
At the same time, it behooves older patients and their family members to be continually mindful of how patient characteristics (appearance, unintentional mannerisms, response patterns and speed, etc.)—and even *self-stereotypes* (Levy, 2009)—can affect provider perceptions and possibly trigger stereotype-driven behaviors directed toward older adults (Roter, Frankel, Hall, & Sluyter, 2006; Ryan et al., 2006; Street, 1991; Wengryn & Hester, 2011).

Despite increasing availability of resources promoting recipient engagement in health care (e.g., http://www.ahrq.gov/patients-consumers/patient-involvement/index.html; accessed July 16, 2015), recent publications and discussions on health communication with older adults still tend to reflect the “one-up” standpoint of the provider and focus on frailties and deficiencies (see, for example, Kobylarz, Pomidor, & Heath, 2006; Wald, Fahy, Walker, & Livingston, 2003; Williams, Davis, Parker, & Weiss, 2002). Reports such as these tend to broadly frame the older population (perhaps together with the less educated) as a *vulnerable* group in a “one-down” position requiring special accommodations. However, the other side of today’s *highly diverse* picture of aging reveals a growing number of adults entering their senior years well educated, still vigorous physically and intellectually, and actively engaged socially and productively (Cook, 2015; He, Sengupta, Velkoff, & DeBarros, 2005; Manton, Gu, & Lowrimore, 2008; Rowe & Kahn, 1997). Indeed, many older adults possess a wealth of life experience—including personal histories of health setbacks and recovery or accommodation—that they are able, willing, and often eager to share (Mermann, Gunn, & Dickinson, 1991). These *survivors* can be looked upon as exemplars of what it takes to marshal resources and, with varying degrees of success, cope with varied and multifaceted challenges (Becker, 1993; Randall, 2013). Thus, older adults have the oft unfulfilled potential to assume a “one-up” position as teachers vis-à-vis medical personnel open to learning from their stories of resilience as well as tribulation (Kumagai, 2008; Mermann et al., 1991).

While not discounting the need to provide seniors with health information that is easier to understand and more readily accessible—an issue covered extensively elsewhere (e.g., Centers for Disease Control and Prevention, 2009; Kobylarz et al., 2006; Meade, 1999; Williams et al., 2002)—this article looks at less commonly addressed health communication concerns that do not necessarily fit the “typical” mold. Consider, for instance, those comparatively well-educated older adults who seek to become more directly involved in managing their intertwined comorbid health conditions. They may have the *whereveritual* (cognitive ability, technical skills, and drive) to enhance their health literacy as needed, yet lack *access* to crucial resources (e.g., full clinical notes, test results, and published research pertinent to their cases). How do prevailing power arrangements affect the potential of these actively inquisitive seniors to become fully engaged as collaborative health care partners?

In this essay, I adopt something closely akin to the “Missing Voices” and “Hard Hitting Critiques” perspectives on successful aging outlined by Martinson and Berridge (2015). I argue that the ideal of comprehensive, coordinated care with a whole-person orientation—as embodied in the patient-centered medical home concept of team-based care described in detail by Stange et al. (2010) and widely espoused as a model for health system reform—can be realized only to the extent that patients and their families are afforded a full voice. This requires that the flux of underlying power relations in medical settings be openly recognized and taken into account. In this regard, older patients are disproportionately at risk for being marginalized. Because they are more likely to be stereotyped as dependent or as possessing diminished capacity simply because of their age (Adams-Price & Morse, 2009), they often start out in a position of amplified disadvantage relative to other actors. Thus, it is crucial that elders and their advocates be adequately prepared to anticipate stereotypic responses, proactively seize the initiative, and ask the kinds of questions that will steer the direction of discourse toward attainment of desired outcomes (Cegala, Street, & Clinch, 2007; Rao et al., 2010).

**Mapping Out Power Relations**

Power, as actualized in health communication encounters, can be understood as an expression of “the multiplicity of force relations immanent in the sphere in which they operate” (Foucault, 1978/1990, p. 92). This Foucauldian perspective looks upon power relations as “always local in scope and unstable, produced moment by moment [and] operating through successive confrontations and continual struggles” (Elissen, 2013, p. 17). Yet, although the balance of power may fluctuate over the course of any given encounter, certain factors will place one party or another in a position of *initial* advantage. Questions pertinent to mapping out these power relations include the following:

1. At any given point in the exchange, *who is in control?*  
   That is, *who has the upper hand?*
2. *How do initial perceptions and ongoing nonverbal behaviors affect the discourse?*
3. *In whose interest* is a procedure being recommended?  
   *Who stands to benefit, and in what way(s)?*
4. *What information is regarded as relevant—and by what parties?*
5. *What information is being disclosed, and what is being concealed—and for what reason(s)?*

Older patients and their families should keep in mind that, as a general rule, the *withholding of information* is a prime avenue for the exercise of power. People are more easily manipulated when they are denied access to critical information, and the management of information (“putting a spin on a story”) is often crucial to molding perceptions of a situation and the behaviors that follow. In a health care
setting, doctors (and to some degree administrators and others) can be assumed to start out having the upper hand over patients in terms of technical expertise and familiarity with health care systems and procedures: “Power, at the most rudimentary personal level, originates in dependence, and the power of the professions primarily originates in dependence upon their knowledge and competence” (Starr, 1982, p. 4).

Models of Health Communication

The paternalism–consumerism–collaboration typology set forth in this section is an illustrative or heuristic device to describe health communication patterns that tend to prevail under conditions of dominant-submissive, adversarial, and reciprocal/give-and-take power relations. Although the following examples are framed in terms of dyadic doctor–patient relationships, many of the observations can be generalized to encompass a wider range of health care participants (including nonphysician providers, administrators, third-party payers, patient advocates and navigators, and family members), and also the shared decision-making processes that transpire in team-based care.

Medical Paternalism

Physicians have traditionally enjoyed high prestige as trusted professionals, based on their specialized expertise, autonomous self-regulation, and avowed dedication to service (Parsons, 1951). They routinely function as key agents of social control (Zola, 1972)—including control over diagnostic labeling, access to many drugs, and validation of claims for special consideration due to health status. In a paternalistic doctor–patient relationship, the doctor presents as a prototypical parent figure, presumed to act out of beneficence on behalf of patients’ well-being; the focus is on obligations, with the implication of trust between doctor and patient (Beisecker & Beisecker, 1993). The doctor is recognized as the ultimate medical authority—with specialized training, skills, and experience that trump patients’ individual treatment preferences—“Doctor knows best.” The doctor takes on a fiduciary responsibility and is “institutionally certified to be worthy of entrusting responsibility to in the field of the care of health … ” (Parsons, 1975, p. 266). The labels applied to roles in the health care relationship themselves imply power differentials: “doctor” (= teacher) versus “patient” (= forbearing sufferer).

Health Care Consumerism

With the widespread proliferation of consumer movements starting in the 1960s (Reeder, 1972), and especially with corporatization and the implementation of managed care (McKinlay & Stoeckle, 1988), the doctor is increasingly looked upon as a hired service provider, presumed to be acting out of self-interest; the focus is on patient rights, with emphasis on accountability (Beisecker & Beisecker, 1993). This model implies divergent goals and mutual distrust between doctors and patients (“Let the buyer beware”), legal accountability, and the practice of defensive medicine (Beisecker & Beisecker, 1993, p. 45). Doctors become dual or multiple agents; their potentially conflicting duties on behalf of patients’ personal health, public health, and cost containment erode both their own autonomy and patients’ confidence (Goodyear-Smith & Buetow, 2001). “He who has the gold makes the rules”—third-party payers and administrators limit the options of both doctors and patients.

Health Care Collaboration

Here, the ideal is for doctors and patients to work together as partners in decision making; however, it cannot realistically be assumed that such a partnership will be equal. The balance of power will fluctuate over time, in response to resources brought into the relationship; “[e]mpowerment of all players is not always possible but is most likely where each party considers and acknowledges power issues” (Goodyear-Smith & Buetow, 2001, p. 449). Conflict can develop when paternalistic or consumeristic assumptions or expectations of either party in the relationship remain hidden (Beisecker & Beisecker, 1993). Doctors’ interaction patterns are often swayed by patients’ personal characteristics and communicative styles—such that the information patients are given often depends to a large extent on their education, emotional expressiveness, and propensity to ask questions (Street, 1991). On the other hand, patients’ readiness to engage can hinge on their sometimes stereotypical perceptions of doctors’ empathy and listening skills (Coulehan et al., 2001). As is the case with community-based participatory research projects (Burhansstipanov, Christopher, & Schumacher, 2005), successful health care collaboration hinges upon the initial establishment of basic trust and effective working relationships. This implies open, above-board, and mutual recognition of often veiled realities concerning power relations—vested interests, bureaucratic and institutional exigencies, perceptions and preconceptions, and so on.

Necessary Conditions for Truly Collaborative Health Care Relationships

Basic Orientation as to Behind-the-Scenes Power Relations

Few senior citizens (or even doctors, for that matter) involved in health care encounters are well versed in or attuned to the intricacies of medical sociology. Thus, many crucial implications of social context, institutional constraints, provider and patient assumptions and expectations, etc., are likely to receive but scant notice. It is essential that critical awareness of unequal power relations in health care be sought out from the perspectives of both the recipient and the provider. Fundamental to such awareness are two overarching principles of critical sociological analysis set forth by Eliassen (2013, pp. 8–9) and generally...
applicable to institutional settings: “money equals power” (thus, “when in doubt, follow the money”) and “institutional structures and policies evolve so as to ensure the survival and continued prosperity of the institution, regardless of its initial purpose and stated mission.”

Some of today’s older adults are reluctant to question medical authority, and indeed may be taken aback when a doctor does not provide a definitive answer. Older patients, particularly those with lower education or from pre–Baby Boom cohorts and in poorer health, are more likely to prefer physician-directed care (Levinson, Kao, Kuby, & Thisted, 2005). This is especially the case among those who report greater trust in physicians (Arora & McHorney, 2000)—and who were likely brought up to rely implicitly upon doctors’ expertise and dedication to service. Also, many elders who were socialized to favor a genteel presentation of self may be inclined to conflated assertiveness with aggression, and thus may be hesitant to call out any patronizing behavior they observe in health care personnel. The upshot is that passive response patterns tend to reinforce ageist stereotypes of frailty and dependency, whereas assertive seniors tend to be viewed as more competent than their less assertive peers (Ryan et al., 2006). Thus, education of older adults needs to foster awareness of the growing complexity in today’s health care systems and the mixed motivations involved. It needs to inculcate the kind of healthy skepticism that will prod elders to ask the right questions and not be satisfied with less than satisfactory answers. Finally, it needs to promote situationally appropriate assertive responses—which sometimes might include explicit patient requests for more directive health care.

On the other hand, health care personnel must be prepared to interpret—and respond aptly to—the sometimes unexpected manifestations of diversity among elders they interact with. For instance, a slow response, puzzled look, or request for clarification may indicate (a) the presence of auditory, visual, or cognitive barriers to communication; (b) a need for simplified information or translation of jargon; or else, conceivably, (c) a desire for more detailed or nuanced explanations. To foster collaborative trust and understanding, it is also important for providers to be forthright with older adults and family members about limitations in their capacity to deliver needed patient care (whether due to knowledge issues or institutional constraints), and ready to engage with health care recipients in active problem solving to better fulfill unmet needs (perhaps through solutions such as more frequent visits or referral to providers with different expertise).

**Equitable Sharing of Health Information and Medical Records**

In essence, the very requirement for obtaining informed consent amounts to tacit recognition of power differentials within clinical and medical research settings—and the way the informed consent process is carried out can be analyzed as an expression of these differentials. As noted earlier, the withholding or concealment of vital information is a prime avenue for the exercise of power over others. Truly informed consent (and full collaboration) demands adequate access by all involved parties to those health records and research findings essential for enlightened decision making. This implies consistent implementation of electronic medical records, including comprehensive histories and test results, fully open to patients and (with patients’ permission) to all their health care providers. The additional practice of sharing clinical notes with patients (as in the OpenNotes project—Delbanco et al., 2012) bears potential to further enhance understanding and trust. Although public access to respected information resources such as Medscape and the JAMA Network has recently been augmented to some extent, primary research reports in peer-reviewed journals are still difficult to obtain without access through academic libraries.

At issue regarding consent forms for older adults is whether to simplify or diversify. The hazards of excessive detail and jargon are well documented (Davis, Holcombe, Berkel, Pramanik, & Divers, 1998; Meade, 1999). Too much information can be overwhelming and trigger needless anxiety. Patients of any age can feel pressure to sign and “get it over with,” especially in a medical crisis situation; older patients often have additional challenges such as impairments in vision and hearing. On the other hand, oversimplification carries its own risks. Consider, for example, the flawed information given to Tuskegee Syphilis Study participants regarding treatment for “bad blood” (Jones, 1993). To what extent was this originally a well-rationalized effort to enlist a marginalized population implicitly stereotyped as ignorant and gullible? In the end, truly informed collaboration requires keen sensitivity to complexities of patient context. More nuanced communication strategies on the part of doctors and nurses may be needed in order to ensure that patients thoroughly understand their health situation and have whatever tools are right for them to make wise decisions based on the best available information.

Equitable sharing of information with health care recipients also demands understanding as to the appropriate unit of care. Providers may have to tailor information so as to meet the needs of significant others (spouses, caregivers, etc.) as well as patients—even where there is no indication of diminished autonomy on the part of the patient. For example, administrative matters (insurance and billing procedures, setting appointments, etc.) can conceivably be a more significant hurdle than strictly biomedical information (benefits, side effects, prognoses, etc.)—especially for older patients and their families who must manage comorbidities and other complex situations. The ideal of integrated, patient-centered care calls for an informed consent process that fully embraces these concerns as well.
Ongoing Health/Health Care Education Involving Seniors

Because today’s baby boomers reaching traditional retirement age are, on the average, far better educated than their parents’ and grandparents’ generations (Carlson, 2009), the ready availability of health and medical information from Internet and social media sources can result in a more knowledgeable older population—or else an illusion of such. An important caveat is a lack of commonly recognized venues within which to normalize frank and open discussion of power relations and attendant issues among doctors, patients, and other involved parties, and thereby facilitate basic trust and effective working relationships. Ideally, such venues would offer safe and comfortable environments conducive to unfettered participation by elders, caregivers, and professionals alike, with discourse preferably taking place in neutral locations (e.g., university settings) not perceived as being the “territory” of any involved party. There should be explicit assurance that all participants are welcome and that everyone’s input is respected and valued.

An array of possible educational venues to engage a diverse spectrum of older adults in discourse relevant to health care might be directed toward attainment of various goals such as enhanced conscious awareness of power dynamics, open discussion of power relations from the perspectives of different stakeholders, or mitigation of power differentials via greater patient knowledge and participation. Such venues might utilize various modes of expression (spoken versus written, face-to-face versus online, etc.). Formats might include the following:

1. Focus group discussions on salient issues identified by participants;
2. Academic symposia with invited presentations by senior patients and other interested parties as well as academic and health care professionals;
3. Classes and support groups in health care settings, senior centers, etc.—potentially offered through organizations such as the Osher Lifelong Learning Institutes (http://www.oshersonline.org/index.php?ollie; accessed July 16, 2015) now on 119 campuses across the United States;
4. Online chat groups, social media, etc. (older people are getting more tech-savvy—and tech-savvy people are getting older);
5. Gerontology courses in colleges and universities (with senior citizens prepared for active engagement—and on call to serve—as consultants, guest lecturers, etc.); and
6. Medical and nursing schools (for example, dying patients serving as instructors for medical students—Mermann et al., 1991).

Reorientation for Individual and Institutional Health Care Providers

A crucial issue is the readiness of health care providers to reinvent the way they operate. In a traditional fee-for-service system that promotes specialization and provides compensation based on diagnosis codes, doctors soon learn to “divide and conquer” (Ahn, Tewari, Poon, & Phillips, 2006)—to identify patients first and foremost as cases of specific medical conditions. This reductionistic approach has failed to adequately address the comorbidities common in older adults and attendant issues such as polypharmacy. Furthermore, clinical trials call for homogeneous disease groups so as to rule out extraneous influences—but in the real world, simple uncomplicated conditions are rarely encountered (Syme, 1996). If doctors are to effectively shift priorities from disease treatment to health promotion in seniors, they will require consistent institutional support and training—as exemplified in the Cleveland Clinic’s (2013) efforts to foster empathy—coupled with suitable restructuring of compensation.

One solution holding promise in redirecting focus toward patients as persons is today’s renewed emphasis on primary care and the patient-centered medical home—defined as “a team of people embedded in the community who seek to improve the health and healing of the people in that community” (Stange et al., 2010, p. 602). In this regard, the life experience of older adults can be seen as a potent but largely untapped community resource—and many active elders stand ready to help in fixing health care. If taken seriously, direct engagement of older patients and family members in institutional planning and policy making—as through pioneering initiatives at the Dana–Farber Cancer Institute—can play a key role in incentivizing the kinds of innovation needed to overcome institutional inertia (Carman et al., 2013).

Conclusion

In today’s aging population, it is increasingly common for elders to experience 30 or more potentially productive years of retirement wherein physical and mental activity, social engagement, and giving back to community become key aspects of self-fulfillment—and new expectations for redirection in the later years of life are coming to displace outmoded assumptions of disengagement (Cook, 2015). Embracing the growing potential of older adults to make significant contributions represents a continuing challenge for social institutions of all kinds in the 21st century (Gonzales, Matz-Costa, & Morrow-Howell, 2015). Educational strategies to foster engagement in actively and truly collaborative health care relationships can be an important part of the picture. Promising interventions to facilitate health care communication in older adulthood might well be directed toward broad objectives such as these:

1. Training both recipients and providers of health care to become more mindful of those sometimes subtle cues that tend to evoke stereotypes and thus activate stereotypical thinking and communication patterns (cf. Djikic, Langer, & Fulton, 2008);
(2) Promoting an institutional culture that normalizes and encourages challenge to stereotypical beliefs and communication patterns, and thus validates and rewards situationally appropriate assertive responses from older health care recipients; and

(3) Formally ratifying the life experience of older adults by utilizing them as recognized and duly compensated instructors and facilitators in the training of health care personnel, with a charge to share their real-life perspectives on aging that include accounts of resilience and success as well as unmet challenges and frustrations.

This list is by no means exhaustive. Its fundamental purpose is to serve as a starting point for generating creative approaches to the active involvement of older adults—together with gerontologists, health care providers, and policy makers—in productive discourse related to aging and health. Let us take on the challenge of continuing to seek out new ways in which to collaborate with seniors—and welcome them as full colleagues—in striving for a better future.

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