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Abstract

This study explores a group of elderly women who were searching for physicians that were interested in providing negotiated health care options with particular interest in mutual decision making. The grounded theory approach was used to explore the health care interactions between the physicians and the elderly women (Strauss & Corbin, 1998). Qualitative interviews were conducted with eleven women, 75 years and older. The categorical working title of "Looking for Dr. Right" helped to focus our discovery of the reasons for these women's search for a new physician. Grounded in the data, a proposed hypothesis was developed regarding the need for a two-way dialogue addressing specific health care concerns between an elderly woman and her physician.

Keywords

Grounded Theory, Elderly Women, Patient-Physician Interactions, Qualitative Research, and Mutuality

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This study explores a group of elderly women who were searching for physicians that were interested in providing negotiated health care options with particular interest in mutual decision making. The grounded theory approach was used to explore the health care interactions between the physicians and the elderly women (Strauss & Corbin, 1998). Qualitative interviews were conducted with eleven women, 75 years and older. The categorical working title of "Looking for Dr. Right" helped to focus our discovery of the reasons for these women's search for a new physician. Grounded in the data, a proposed hypothesis was developed regarding the need for a two-way dialogue addressing specific health care concerns between an elderly woman and her physician. Key Words: Grounded Theory, Elderly Women, Patient-Physician Interactions, Qualitative Research, and Mutuality

Introduction

Strauss and Corbin (1990) contend that each researcher brings to an inquiry a considerable background in professional and disciplinary literature. To be more open to the kind of communications that elderly women have with their physicians, a brief review of some articles about elderly women and their interactions with physicians was conducted prior to the research. An additional literature review was conducted at the study's conclusion, relevant to theories and research about physician-patient interactions. The review before the study helped to avoid viewing the participants' interviews through a single prescribed lens.

In this article, we examine a group of elderly women's perceptions of their interactions with their primary care physicians. Having worked as radiographers, collecting diagnostic information allowed us to become familiar with older women's chronic health issues and options for health care. Our academic preparation made us familiar with published works that dealt with patient communications that provide a medical diagnosis and treatment. Professionally, it has been advocated that the best treatments for women result from careful discussions occurring with various experts during the diagnosis and the treatment phases of care (Bergsma & Thonmasma, 2000). Complicating these communications is the fact that women of advanced age have a propensity for suffering from more than one chronic disease (Wilcox & Stefanick, 1999). This can complicate a discussion about best treatment options, since elderly women have multiple concerns and need detailed descriptions of various treatment options. This often results in time consuming and complicated conversations, which can be misinterpreted by physicians as being characterized as the patient being indecisive (Makuc, Freid, & Kleinman, 1989).

Elderly women have reported being intimidated prior to and during their physician's visit. Some of this apprehension might be related to a struggle for clearly articulating their health care concerns. Unfortunately, this anxiety can be heightened due to a physician's tendency to impart her/his knowledge and recommendations through a one-way style of communication (Ishikawa et al., 2005).

Previous studies have focused on examining a one-way style of communication that is hallmarked by either the physician or patient communicating without concurrent discussion (Hall, Roter, & Milburn, 1996; Jenkins, 2003; Marek, Popejoy, & Petroski, 2005; McKinlay, Burns, & Feldman, 1998; Quill, 1983, 1989). These studies have documented that a one-way physician-patient communication has the tendency to exclude the patient from the decision process. One-way interactions between patients and physicians have been addressed by trying to sensitize medical students to the need to listen more carefully to their patients.

This is not an insignificant problem, as persons over the age of 85 in the United States will increase in number by a factor of five in the next 50 years (Bergsma & Thonmasma, 2000). As this significant group of health care consumers search for a physician-patient relationship, they are interested in a relationship that honors their values and ability to make informed decisions. The literature supports the fact that women are more likely to find a desirable physician by "word of mouth." Endorsements provided by other people, neighbors, family members, and current patients have been reported to provide better than a 50% influence on the selection of a new physician (Goodman, 1999).

The fundamental focus of this study was to describe and analyze the types of interactions that elderly women experienced with their physicians. We began this exploration by trying to discover what types of health concerns had developed in a group of elderly women living in a retirement community. The next part of this study was to allow the women to discuss their options for handling chronic health conditions. Certainly, those elderly women with chronic diseases are more likely to have complex conversations with their physicians and have more chances of being frustrated with articulating their health care needs. By directing analytical attention on the communications that occur between elderly women and their physicians, this work highlights the dilemma of this growing group of women in the United States. It also calls attention to the need to develop more participatory spaces for elderly women to have dialogue with their physicians regarding their diagnosis and treatment options.

Grounded Theory

A grounded theory methodology was selected to guide data collection and the qualitative data analysis (Strauss, 1987; Strauss & Corbin, 1990, 1998). Hallberg (2006) has described a scheme for segregating grounded theory into paradigmatic approaches or types. She has suggested that grounded theory can be situated into three differing approaches. Glaser's training at Columbia University imbued the early form of grounded theory with dispassionate empiricism and is locked into a more quantitative rigor (Charmaz, 2006). Strauss's training at the Chicago school created a different approach which centered on change over time and actors having the chance to react to these conditions (Corbin & Strauss, 1990; Strauss & Corbin, 1998). The third type of grounded

theory is attributed to Charmaz, who has a constructivist approach to grounded theory (Charmaz, 2006). Since the Straussian approach is centered on change over time and participant reactions to these changes, it seemed to be best suited to our research endeavor given that we asked elderly women to recall changes in their health, their reaction to selecting a new physician over a period of time, and the conditions that surrounded that decision. These accounts can have the added benefit of uncovering issues or concerns that have not been anticipated or previously considered (Pope, van Royen, & Baker, 2002).

Position of the Researchers

This was a follow-up study to a quantitative research project that we staged in several retirement communities more than a year before. Because we had conducted an in-service training and visited with these women in their apartments, we had a great deal of access and comfort working with them again. Due to the previous study being staged as a health education intervention, we were acutely interested in the current health statuses of all the original participants. Also, our extensive background in imaging technology often centered on assisting older women with chronic illness concerns. These experiences gave us added insight into elderly women's difficulties with obtaining health care.

Funding for this project was provided by the college as part of a hiring package which allowed this study to be staged at our discretion. All of the communities that were recruited for the quantitative study were actively participating in the services offered by the university at the graduate level. This created a positive environment for the elderly women to participate in university research. This research involved a series of three interviews with each participant, and the information was obtained without judging the responses or offering opinions on the decisions they made. All the elderly women were offered a home visit with the university's medical students as part of an institutional agreement, which provided an optimal pathway to allow severe health conditions to be properly attended. University medical care was not a selection requirement.

Sample Characteristics

This qualitative research project was conceived as a follow-up to the quantitative study of 100 elderly women who were recruited for a preventative health intervention and were dwelling in assisted living communities throughout the central Ohio area (Evans & Bates, 2005a, 2005b). The original study divided the women into groups at the community level. Communities were assigned to either control or experimental groups. To obtain follow-up qualitative data, experimental communities were contacted to obtain permission for participant interviews, one year after the original study. A key facility for staging the qualitative study was one in which 20 elderly women had participated in the original quantitative study. This retirement community attracted fairly affluent residents. It was the largest of the original facilities that provided participants from the original study.

The Activities Director in the key community obtained institutional approval to invite these 20 original women to rejoin the study. The selection of participants, known

as purposive sampling, has been described by Corbin and Strauss (1990) as the deliberate selection of individuals or communities in order to study concepts, their properties, dimensions, and variations. Open sampling was attempted by inviting all 20 elderly women from the key assisted living community to join the follow-up study. Of those 20 women, 8 elderly women provide personal in-depth interviews due to deteriorating health conditions (3 additional women from an additional research site were also included in this study). The participants' ages varied from 75-90 years and each had taken residence in an independent apartment which was connected to a central assisted living facility. All but one woman still owned a car; however, very few of them were still driving long distances.

Only one woman had been single all her life, the others had been married and were now widowed. Although the women were from varied backgrounds, they each had acquired enough personal resources to purchase extended health care provided by the assisted living facility. The women would be considered affluent as they had the resources to buy into these communities. Their educational level was some college after high school, and all of them had been working in the business world. Their families did not live in this area of the country, so the assisted living facility was an added security benefit.

Data Gathering Methods

Our research team approach was strengthened by the first author having doctoral preparation as a gerontologist and the second author was enrolled in the nurse practitioner- MS program. These academic skills were built on to our clinical background in radiology. Our proposed qualitative research project was approved by the Ohio State University's Internal Review Board prior to the beginning of data collection. An interview guide was developed with broad themes to use in the first, second, and third interviews (see Table 1). The first interview was designed to capture the health of the elderly woman over the last year. The second interview was fairly unstructured, so that issues that surfaced from the first interview could be more fully explored with regard to their frustrations with her physician. The final interview was required for all participants to determine the barriers that kept the women from seeking a new physician to help them with alternative health care decisions. This series of all three interviews was necessary for the participant to be included in the study.

Roter and Hall (1997) have proposed some important elements which are part of the affective quality of a patient-physician interaction. The three levels that were suggested were intrinsic, conveyed, and interpreted. The intrinsic level relates to personal values of the physician, which can frame his/her options for health care. The conveyed level is descriptive of the information that is actually spoken to the patients. This can be perceived as caring but may lack evidence of competence to elicit compliance with the suggested care plan. The interpreted portion of the interaction between the physician and the patient describes the information that is heard by the patient and reciprocal exchange is advocated to evoke more of a consumer mentality (Roter & Hall, 1991). Of the three levels provided, the interpreted or elderly woman's impression was what was investigated during this qualitative project.

Table 1

Interview Guide Utilized during the Interviewing Process

Capturing health status	***Capturing MD frustrations***	***Capturing barriers***
Interview #1	Interview #2	Interview #3
Q1. Describe your health over the last year.	Q1. Give some examples of your interactions with your doctor.	Q1. What things are keeping you from getting the kind of care you desire?
Q2. Tell me about your most complicated recent health problem.	Q2. Describe your most recent office visit.	Q2. If you could describe the ideal situation or method for resolving these issues, what would that look like?
Q3. In what ways is your health different than the last time that I visited you?	Q3. In what ways did the visit not settle your health issues?	Q3. Describe the ways that a doctor could help in making medical decisions.
Q4. What kinds of measures are being used to get your health problem under control?	Q4. Describe a typical list of concerns that you provided to the doctor.	Q4. What qualities should a physician who cares for elderly women possess?
Q5. Describe a typical day for you since you have had a change in your health.	Q5. What things did not get addressed at the visit?	Q5. What steps are you going to use to resolve your remaining health care issues?
Q6. What kinds of adjustments have you made since this condition has developed?	Q6. How do you intend to resolve the issues that still remain since your last visit?	Q6. What assistance do you need to get your medical issues settled satisfactorily?

The initial interviews of the first eight women were conducted in their personal living quarters or a secluded area within the retirement center to allow the elderly woman to have privacy to describe her health and the problems she had encountered over the previous year since the first study. One of the most intriguing topics mentioned was the participants' dissatisfactions with options provided by their primary care physician. Discussing this topic after the first interview, we decided to refocus our discussions on how these older women felt about their interactions with physicians rather than on their chronic health conditions. The elderly women, who were recruited from the largest retirement community, were all given a chance to comment on this topic and shared their stories and frustrations. This was surprising to us as we were unaware of their ongoing health issues and the involvement of their primary care physician.

The second interview was used to follow up with each participant and discuss each woman's options for handling her chronic health condition(s). We were determined to allow each elderly woman to have the freedom to talk about any option, no matter how untraditional or unconventional it might seem. A graduate assistant was present at all the interviews to insure that tape recording was accomplished as well as compiling our field

notes. We also reviewed all the data collected during the first and second interviews, and we did initial analysis to look for any connections among the participants. The third interviews were designed to conclude our discussions of the various medical intervention options and the progress that had been made to find alternative health care.

Throughout the interview process, we worked to document all the barriers that were keeping the elderly woman from obtaining the help she needed to act on her desire for alternative health care. In total, the eight elderly women provided three interviews for more than one hour each, and these twenty-four interviews and transcripts were carefully coded along with the field notes. One couplet of codes we used was a primary or "parent code" of MD/PT relationships and a sub-code or "child code" indicating whether it was perceived as a positive or negative interaction. An example would be the parent code applied to this passage: "I mean he actually sat down to talk to me. And I don't think he had ever done that before (laughing)." Interviewer: "Oh, so you saw a side of compassion that…." Participant: "…that I had never seen before from him!" This was further marked with the child code, as a positive interaction.

At this point, data analysis did not provide consistency, so we felt that saturation had not been reached. Since we could not gain access to any more of our original participants, we moved to the next largest retirement community involved in the original quantitative study. From the second facility, an additional set of three elderly women agreed to join the qualitative interviews, which increased our total number of participants to eleven. Their three interviews added an additional nine interviews and associated field notes for coding and analysis. This set of three interviews with a trio of elderly women provided additional rich narratives that upon further analysis, confirmed that saturation had been achieved.

Data Analysis

The analysis of the data captured from the three extended interviews with each of the women was built using grounded theory (Strauss, 1987). Each interview was tape recorded and transcribed for analysis throughout the data collection process. Once the transcribed interviews were received, line by line open coding was done with each interview. An example of the line by line coding was an exchange between a participant and the interviewer.

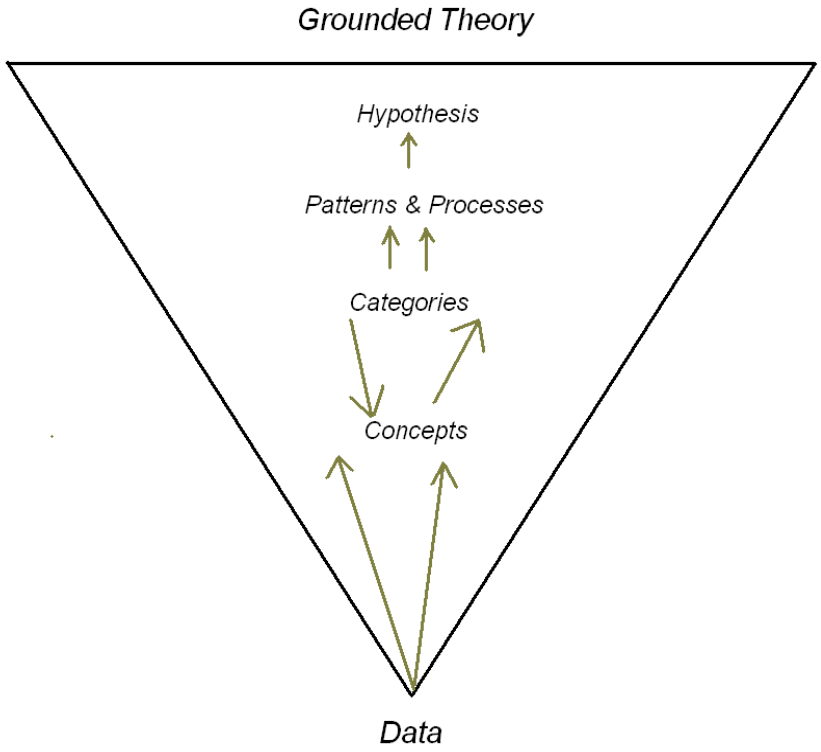
> Participant: [I think Dr. L is right next to God..."] *MD/PT relationship*
> Interviewer: Well, you must have a good rapport with him?"
> Participant: ["Yes!"] *positive relationship*
> Interviewer: How is that established with a physician?"
> Participant: ["Well, through the years you build up…but it seemed like we had it right away…there just some people you like..."] *long standing relationship*

Data analysis was guided by the steps proposed by Corbin and Strauss (1990, 1998; See Table 2). First, data collection and analysis was carried out systematically and sequentially, which allowed the researcher to capture all relevant information as soon as it was detected. This study accomplished this step through the coding of initial bits of

information and using all relevant information incorporated into the subsequent sets of interviews and observations. Next, conceptual labels were given developed codes as the process of analysis continues.

Table 2

Corbin and Strauss's Specific Procedures for Data Collection and Analysis (1990).



In this study, elderly women's access to physicians was compared and additional information was provided which seemed to fit together into a pattern such as finding transportation with another elderly woman. These similar stories indicated that these common issues of transportation were not some isolated phenomenon. Some examples of conceptual labels were MD/PT relationships and Access to a MD. Concepts were grouped to form categories as the next step of the process.

As the analysis continued throughout the project, the need to establish a doctor-patient relationship was compared to highlight similarities and differences, which were used to develop lower level concepts such as the search for a new physician with specific qualities. A common category that related many of the elderly women's personal experiences was titled, *Finding Dr. Right*. As the interviews continued, participants articulated their different needs, as it related to finding a new physician who possessed certain attributes and qualities. This desire to find a new physician was what interested us in capturing this phenomenon. We asked each participant about how important it was to locate a new physician.

One common experience for the elderly women can be grouped through axial coding as a conceptual label, such as "access to a physician." Working with this label

allowed for data collection relative to participants' experiences obtaining a physician visit, given they were now residing in an assisted living facility. As the subsequent interviews progressed, participants provided personal experiences with getting physician visits and the quality of interactions. As the analysis and data collection occurred in an integrated fashion, the category that was dubbed, *Finding Dr. Right*, began to emerge. As the analysis moved forward, the concepts that came from the line by line coding of the interview transcripts and field notes, were compared across all the participants' interviews and noted to connect with this category in some manner. Next, analysis was conducted by comparing an incident against other reported incidents. As the data collection proceeded, each new interview provided fresh data and descriptive incidents provided by the participants. This was used to continue the constant comparative process (Glaser & Strauss, 1967) and to determine the consistency among all our elderly women's search for just the right kind of new physician.

It was also important to take processes and be sure they are broken down into stages, phases, or steps. In this study, asking the elderly women to talk about a typical doctor's visit and breaking it down into the preparation to travel to the office, recruiting a friend to come along, parking the car, waiting in the lobby, preparing the list of questions, and then trying to communicate with the physician were all part of the intricate steps that were articulated and compared among the participants. Memos are important part of the research, as they assist in the formulation and revision of theory during the research process (Corbin & Strauss, 1990). A memo is a note or series of impressions that are made by the researchers as they analyze the interview data. These memos are preserved and utilized as part of the analysis process to help make additional sense of the data.

Next, hypotheses were developed and verified, which sometimes meant returning to the field for further revision and development. To achieve consistency and make sure that additional information was captured, a second facility was contacted to obtain interviews with three additional participants. This helped to solidify the categories, as well as, provide data saturation. This was done to insure that no new information was gleaned. Memoing and further analysis fortified the need to return to the field and was the rationale for adding the three women from the second facility. In this project the recruitment of additional elderly women and conducting their interviews allowed the chance to confirm the evolving hypothesis concerning the need for two-way communication and negotiation.

An added step was to invite collegial sharing and allow others to scrutinize the data. Throughout the process, theoretical sensitivity was invited by seeking input from a colleague in qualitative research from another department in our school (Dr. Taylor) and creating space for the graduate assistant to provide ideas and reflections which challenged our assumptions regarding the data. Discussions between my qualitative research colleague, Suzanne, and myself allowed for a more collective approach to understanding what was being articulated by the participants. This process of allowing corollary interpretations and entertaining alternative results has been termed discipline restraint (Hall & Clallery, 2001). Allowing multiple perspectives to infuse the analysis process made the building of connections between categories to be more rigorous. Dr. Taylor offered some insight as to cultural differences that could also color our research discussions, based on his work with Native Americans. Dr. Taylor's experience with communication difficulties with medical professionals and Native Americans was helpful

to understand how perceptions during a medical visit can be misinterpreted. Finally, an analysis of forces that may be acting on the participants, such as economic conditions, cultural values, etc. is very important. See Tables 3 and 4 for samples of data that were transformed by these analysis considerations.

Utilizing discipline restraint allowed the analysis process to be more inclusive and worked in tandem with the mechanics of coding and creating memos. A member check was also built into the process, however only one of the elderly women involved in the interviews was willing to read the interview results and make comments as to the transcription accuracy.

Ethical responsibility in conducting this project was paramount, and to that end the research was conducted with heightened sensitivity to their experiences, knowledge, and power (Foucault, 1981). It was important for the elderly women to not feel manipulated in the sessions and respond as they felt appropriate throughout the process. An additional responsibility was to properly represent each participant's dialogue with our team. Their conversations were presented as an example of their freedom of expression, and in no way were altered to fit our agenda (Lyotard & Thebaud, 1985). The ethics of allowing participants to express their ideas and issues were an important part of this project, and we sought to not let the researchers' bias steer the conversations and data analysis. For example, we did not want to impose our idea of what constitutes a quality interaction between a physician and a patient.

Table 3

Memos Attached to Transcripts

Searching for "Dr. Right"	**Physical Issues**	**Transportation Issues**
Patient-MD relationship	Walking with a limp	Need for assistance with medical appointments
Taking charge of health issues	Pain in back and legs	Locating an MD close to the facility
Withholding medical issues due to lack of confidence in the provider	Weight gain	Scheduling a friend to help with the doctor's appointment
Patient-MD reciprocity in conversation	Low bone density test	Lack of a car
History of physician interactions	Using a cane or walker	Fear of driving a long distance
Positive interactions	Fear of leaving independent living	The husband had been the driver prior to his death
Negative interactions	Inability to exercise	Cost of fuel to run the car

Table 4

Codes and Statements that Related to the Layers of Analysis

Searching for "Dr. Right"	Physical Issues	Transportation Issues
MD conversation: "You really don't get a whole lot of feedback unless there's a problem and then they tell you…see with the blood test now…for a while we were getting copies of blood tests but lately I haven't seen one."	Exercise: "I could, obviously I could do it. I'm just not motivated because I know as soon as I do I'm gonna think I have a problem and then I won't know what to do about it. I guess that I am hiding my head under the sand."	Transport: "She's much younger than I am...but she had a van and she came and you know…I always…but now, she's having back problems and she's using a walker, not a walker. . . a cane, and so she was my mainstay. When I had surgery, she came everyday and helped and…."
Negative: " Well it doesn't bother me because I know it saves the doctor time and I know that they're busy and so I try to put myself in their place but if I were a doctor….who just pushed me off, I wouldn't go back to him."	Walking: "I had a knee replacement in 2000, yeah my right knee. The other one is acting up but I don't want to in last year. Now I don't want to go in until they get through revising our health center."	Scheduling transport: "My foster grandson works Sunday mornings, so then I have to call somebody to arrange transportation and you hate to be…we had a British man who said he didn't like to have a 'a cap in hand'…that's what you feel like your doing!"
Withholding: "You go meet somebody that you haven't met before and especially a physician and you're scared, you go to a physician and they're gonna tell you something that you don't want to hear and some people I think hold back….they don't give….they don't tell their physician everything."	Assistance with walking: "He (MD) says after two months, he told me to throw away my cane, throw away my walker and just walk…….that was down right crazy!"	Assistance with driving: "They came over here for a couple of weeks after that…I says why didn't you tell me you were driving? I had went and bought a car….it just looked like a good buy when I bought it!"

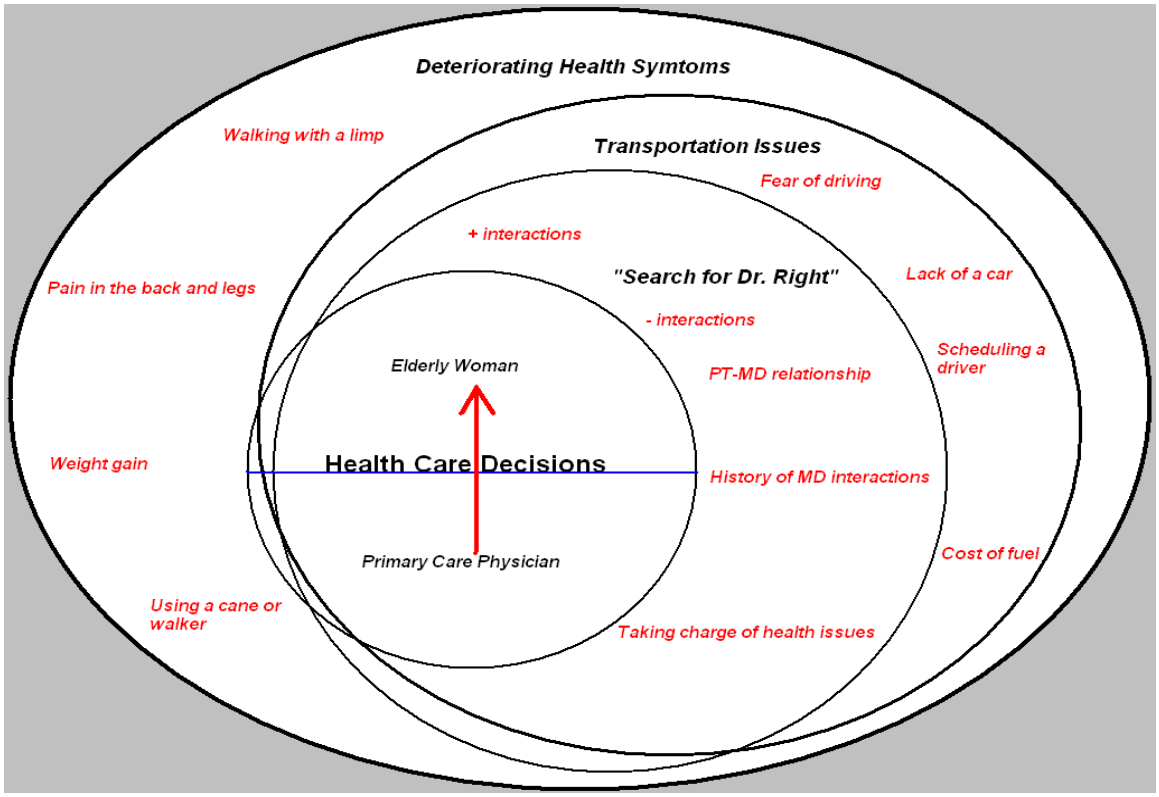
Results of Selective Coding

The grounded theory process requires the collection and analysis of massive amounts of data, transcripts, and interviews to detect relationships and interrelationships as one works to develop a proposed hypothesis. In many respects, the research process has been described as pealing the layers of an onion. With our work, we found that pealing the initial layers is difficult and often shreds or even unintentionally pulled apart deeper layers.

One example of this tenuous process was our initial assumption that participants were looking for a new physician based on difficulties traveling and also scheduling another older woman to drive or ride along. As we pealed this superficial layer of transportation away, we discovered from our participants that "sisterhood" was connected to more than just travel. Taking a trusted friend from the facility helped in many interconnected ways such as building confidence, helping to foster discussion, and sometimes leading the dialogue.

Regardless of the difficulty, we carefully worked to preserve the outer layers and meticulously revealed the conceptual units that became categories. By continuing to analyze each elderly woman's personal account of interactions with her physician and then comparing across experiences, we were able to develop a better understanding of a core issue. Working with these elderly women and their health care concerns allowed us to begin to move from broader topics, to reveal the more interwoven issues related to their frustrations with physicians. At first the issues of transportation and deteriorating health seemed to be extraneous, but actually these formed what has been referred to as a "conditional matrix" (Strauss & Corbin, 1989, 1990). A matrix was been used to map out the layers that were encountered and how these layers represented interrelationships leading to the proposed hypothesis; a need for two-way communication and negotiated health care decisions. A model was designed to help visualize the different circles of influence that were described by these elderly women and are displayed in an overlapping way much like the elderly women encountered them (See Figure 1).

Figure 1. The conditional matrix of selective codes and their overlapping influences on negotiated health care.



This diagram was used as a way to try and make some sense of related factors and helped us to map out the influences that were articulated by our participants.

Outer Layer - Deteriorating Health Symptoms

Besides dealing with increasing age and chronic health conditions, all our participants reported increasing difficulties with their walking and gait. Aging and deteriorating health symptoms acted as a catalyst for locating a new physician who would allow them to discuss a variety of medical options. Resistance to providing dialogue that included options, generated by these older women, meant it was urgent to find a more supportive physician. Contemplating hip surgery or a knee replacement made finding a physician that would allow an elderly woman to participate in her own health care necessary. One participant explained how she noticed that she was not the only elderly woman facing deteriorating conditions.

> People around here, I guess we all have our problems so we don't talk about those, to be truthful and I have a friend that I really think has some problems and this is a problem that I think most of us have...we see our friends and acquaintances deteriorating and we don't know whether we should talk to somebody about it, talk to them about it, ignore it, take it as well, it's gonna happen anyway.

All of our participants discussed how they had dropped out of the exercise program that was provided by the community. The exercise programs were supervised and often had a physical therapy student working with the residents. Unfortunately, our participants dropped out of the program due to their deteriorating health and pain doing the low impact exercises. All our participants wanted to talk with a physician about their physical symptoms because these symptoms were limiting their participation in facility events and often caused them to become isolated. Most of our participants had a list of these kinds of concerns that needed to be shared with a physician.

The information provided by the participants displayed a pattern. All the women were interested in individual attention, as well as the need for their physician to focus on a list of physical concerns. All the participants talked about going to a doctor's visit with a detailed list of the concerns and issues that needed to be discussed during the appointment. Making a list of concerns was common and helped to keep our elderly women focused. It also insured that all the issues were addressed during the visit. One of our participants explained her need to make a list, "...well, you forget if you don't have it written down."

Retrospectively, examining the typed transcripts revealed that, except for our oldest participant, negative office visits stemmed from poor interactions with the new physician and resulted in searching for a more supportive physician. These visits left the elderly women trying to decide how to deal with their medical concerns. Most of the women seemed to have been satisfied with earlier physician visits. Negative office visits often occurred when an elderly woman came with a list of concerns and the appointment time ended before all her questions were answered. One elderly woman described a physician who was too busy to answer questions from her list of prepared questions.

> You really don't get a whole lot of feedback unless there's a problem and then they are quick to tell you how you should feel. Sometimes I think you have good give and take with…with a physician and if you don't feel that, then you are looking for someone else.

The positive patient-physician discussions were usually described as a previous long-term relationship that centered on a chronic disease. One of our elderly women talked about a cardiologist who acted as her primary care physician and how she felt about her personal experience with him.

> He's about ready to retire too, cause he used to say, I'll tell you five years but anymore I'm just going year by year...I'll be here next year...I can't say I'll be here in five years. So anyway…it's like for a doctor to help you, you have to like him and have a lot of faith in him...I think (my doctor) is right next to God!

A trend also seemed to be developing for participants to look at alternative forms of medicine, since they felt frustrated with finding a physician sensitive to their needs. One of our participants discussed her desire to become more reliant on alternative medicine therapies for problems with her legs and back. She talked a great deal about becoming involved in yoga and how she had formed a group of women that regularly went to yoga together.

On the third interview with our first participant, she allowed us to evaluate the letter she wrote to her physician. The letter had been returned and the physician had written on the letter as his form of communication to her. Examining the letter sent by the physician was very distressing because the physician's written comments represented a directive rather than an invitation to discuss alternatives. Conducting a review of the original letter, we discovered the doctor had actually used it to write his response. The letter was hard to decipher due to the additional hand writing on the letter. The elderly woman had to call the office to get a better understanding of why additional handwriting that appeared on her letter and if it had indeed contained the doctor's comments. She later provided us assurance that she was able to move beyond the physician's closed communication and secure her medical alternative.

> [So, did you ever get your knee looked at or…I know you wanted to get a referral…did he give you a referral?] Yes, he gave me one. I had to give him the names of two doctors from church, people at church who'd had their surgery. He wasn't happy but…he selected one of them.

Middle Layer - Transportation Issues

When the project began with the first interview, one of the issues reported by the initial participant was the problem of giving up a physician and finding one that was located closer to the assisted living facility. This issue was repeated by all of our participants who either were dealing with a health situation or an ongoing problem. The idea of giving up an established physician relationship in order to find something closer

to the facility was very frustrating. A program was begun by the local medical school to provide 4th year medical students to make home visits with many of the residents. Our participants liked these visits, but it only underscored how a physician that was local or within the facility made it easier to deal with health issues. This concept was repeated throughout the interviews of all our participants as they began to seek out a new physician who would provide them with medical services.

One of the big issues related to finding a new physician was transportation. The facility did allow the elderly women to keep their cars, but each participant mentioned the growing concern of not being able to drive as they became older. Trying to find a physician that was within close driving range or at the assisted living facility was highly desirable. Further probing into the issue of finding a new physician within close proximity to the facility meant giving up on the idea of "house calls." One of our participants was an elderly woman with complaints about her hip, and she discussed the problem of losing the ability to talk with a physician at the facility. Since her physician did not come to the assisted living facility, she had to drive to the physician's office on the east side of the city. She explained her situation this way,

> Well the thing was they (the doctor and assistant) came here (her apartment), now they don't do as much coming here as they did at first, that could be something with Medicare…licensing, and all this stuff, but mine used to...if I have anything else I go the office. Usually she answers my questions. I mean if they didn't I wouldn't want to have them for a doctor very long, you know.

Driving to obtain medical services also meant that they would need a companion to assist them with parking the car and getting into the office. This type of assistance developed among the residents, as they relied on each other to serve as companions or drivers. The elderly women worked together to make the transportation to the physician's appointment easier and provided personal reassurance. These women had already begun sharing their frustrations with locating a new physician to provide medical care. Some of this came about through locating car pooling options for physician visits. These frustrations articulated by our participants made it evident that this was a significant issue and much more important than the quantitative research that we had conducted previously revealed.

Relationship Between Layers – "Finding Dr. Right"

Collectively, the elderly women that were interviewed expressed a frustration with locating a new physician who was also sensitive to the needs of an elderly woman. This topic was discussed during the interview with our first participant. The participant was eager to report on her health, since she had been a part of our earlier study. Unfortunately, she had developed a great deal of pain in her hip and was interested in getting some advice on how to handle this problem. Allowing our interview to incorporate as much data as possible, she went into some surprising detail about how disappointed she was with her current doctor's visits. She had been suffering with a great

deal of hip pain, but she had been unable to get additional information about hip surgery from her physician.

Shortly after the first interview, additional information was provided by the elderly woman who had sent her physician a letter about leaving his practice. This was quite surprising as this had escalated over the week since the previous interview. She described her physician's communication style as follows.

> You see he's the kind of doctor who walks in and says, "How are you?" and then he starts inching for the door. Oh, I guess you can't expect the old family doctor that sits down and, you know, with today's world. I guess he is really good at diagnosing a problem. He is supposed to be really good at that.

It is not uncommon for elderly women to inform physicians of their decisions by writing letters. This may be a generational habit for these women to write letters, such as to family members, during times of separation. What is unfortunate is that this style of communication results in a one-way style of communication with the physician. The use of the letter as a conduit for communication between the doctor and the patient was not an optimum form of communication. It seemed to us after listening to the participant and examining the series of letters sent by the physician, that both were frustrated at not arriving at a solution to the health care problem due to this one-way style of communication. This repeated category of securing sensitive physicians for elderly women seemed to fall under the working title of *Finding Dr. Right.* The discussions had now become very repetitive and it became obvious that this issue had been discussed independently by all our participants. This issue of quality interactions with the physician seemed to be consistent across all the interviews.

Finding Dr. Right was an abstract way of tracking this category and we combed the typed transcripts to locate incidents and statements made by the participants that might be related. It was through this process of thoroughly analyzing the typed transcripts and line by line coding that it became apparent how participants were struggling with patient-physician interactions. It was through retrospective review and prospective questioning that it became clear that it was more than finding a suitable physician; it was about getting more direct communication. *Finding Dr. Right* was no longer inclusive of the phenomena being experienced by these women. The conversations really indicated a need to move into a two-way form of communication that provided a space for elderly women to negotiate and make decisions about their healthcare. A web between deteriorating health conditions and searching for a new physician to address personal issues were connecting that better described their situation. A hypothesis was taking shape that connected all these concepts and categories. It seemed clear to us that we had found a source of the discontent among the elderly women and had been able to name this phenomenon that we had been struggling to understand. Truly these elderly women were seeking participatory spaces in which to plan their health care.

Relationships between Layers - Support Groups or "The Sisterhood"

One of the strategies that worked to get individual attention from the physician was to allow the companion or "sister" to participate in the office visit. Sometimes the request to include a support person in the exam room was met with opposition. This was vital for getting all the issues addressed and making sure that the information was captured. The support that elderly women had from within the community was truly amazing and this became a defining feature of their healthcare. All our participants were interested in treatments and therapies that could allow them to remain in the attached assisted living facility. This would allow the "sisterhood" to prepare meals, shop, and otherwise supervise their recovery. This support mechanism was a vital part of making decisions about treatment options.

One elderly participant had developed a group for women who regularly met to provide support and care for one another. At one of the meetings of the support group, a discussion centered on the selection of a physician that was sensitive to the needs of older women. This participant provided an explanation of how the support group formed.

> I've gone through doctors and I've talked to my friends about not liking this or that and we've kind of come up with some ideas about how we can deal with that. I have a group of six of us that meet together…at least once a month and we started doing this because...oh it's been 10-12 years now that we've done this…We thought we would just look at issues as we grow older together and it has been very helpful. It really is helpful especially if you go to meet somebody that you haven't met before and especially a physician and you're scared, you go to a physician and they're gonna tell you something that you don't want to hear and some people I think hold it back…they don't give...they don't tell their physician everything.

The participants told us that they felt strongly that their physicians had a hard time understanding the reason for involving support women in the office visit and the treatment options. Our participants felt this was a non-negotiable issue.

Frustrated with the doctor's responses regarding her interest in hip surgery, one of our participants began to do her own research on the Internet to explore other medical options. This participant also decided to discuss her problem with a close friend from church who had undergone a recent hip replacement. The woman's friend gave her the following advice on changing physicians.

> Yeah, cause last Sunday I was really miserable and I happened to see the lady that had a hip replacement at church and I said well, did she see somebody beyond her family physician and she said yes and so she gave me the name of her doctor and that she had gone to him six months before the surgery.

Hypothesis-A Need for 2-Way Communication and Negotiated Health Care Decisions

The elderly women described in the subsequent interviews the importance of seeking a new physician closer to the community, as well as trying to find one that would allow them to participate in the decision-making process. This became very clear in a follow-up interview with one of our participants who described her difficulties finding a gynecologist. Moving to our city from another community meant finding a new gynecologist and she had been searching for a physician that would provide choices in her health care. Unfortunately, the elderly woman went for her first visit at the gynecology office and the discussion was very short and uninformative concerning her abnormal Pap smear. This incident was very upsetting and upon talking to her primary care physician she confided how she felt mistreated in the gynecologist's office. The primary care physician explained that the new gynecologist was in the middle of an unpleasant divorce. However, our participant responded, "I still don't think that he should have talked to me that way….."

This particular elderly woman was seeking treatment choices which were dependent on the physician participating in a dialogue that allowed the woman to discuss her concerns. This idea of being presented choices and being allowed to participate in dialogue was further discussed by our oldest participant when she described a quality physician discussion as having "good give and take." This additional data helped to further define this category as more than just patient-physician interactions, it was more precisely the ability to have an interactive discussion during the physician visit.

Negative case analysis was completed by encouraging our oldest participant to discuss the wonderful relationship she had with her cardiologist. Discussing the relationship with her cardiologist, she confided that her second husband had been a physician and she really felt that this might have influenced her relationship with this physician. Nevertheless, our participant had a very direct and persistent nature which may have been the reason that the cardiologist provided primary care. Due to her inability to keep traveling to his office, she described her final doctor's visit in this way,

> Now, if…he wants to know what's bothering me other than just my heart...like he's …and another thing…when I talk to him its sort of like a friend…he's not just a doctor to me. Through the years you build it up…but it seemed like we had it right away…That just some people you like…

Within the second facility three women were happy to rejoin the follow-up study and provide updated information on their health conditions. In the second facility the women provided telephone interviews since their assisted living facility was at some distance from our campus. Due to issues of weather, distance, and timing of the study, this added data was analyzed at this particular juncture later in the study. The elderly women in the second facility each related being hospitalized over the year since the original study. One elderly woman in particular had nearly died because she was over-medicated during her inpatient stay. Luckily, the elderly woman had a niece who was able to monitor her care and noticed that her oxygen saturation was dangerously low.

Over-medication had hampered her breathing and resulted in a very critical condition. Experiencing hallucinations and a feeling of being out-of-control haunted this elderly woman, and she definitely felt that her doctor was not closely monitoring her condition. She believes her niece saved her life by questioning the staff as to her aunt's low oxygen saturation level. This elderly woman was left with a strong distrust of her primary care physician and is convinced that she cannot continue to have health care delivered in her local hospital. She has directed her niece to draft documents that place her as a legal advocate for her medical condition. She has a total mistrust of her physician because she sincerely believed that he was "all knowing and was supposed to be looking out for my best interests."

This additional data provided by these women provided conversations and experiences, which helped in the continual use of a constant comparative method (Glaser & Strauss, 1967). It also allowed for a more rigorous definition of this phenomenon, by adding more of these experiences and verifying that this was a shared experience by those outside the primary facility. The story provided by the elderly woman who had grave mistrust of her physician during her hospitalization, pointed to a lack of communication by the physician as to her medication, and how this made her feel completely out of control and totally dependent on her niece. The loss of control and a feeling of having no input into health care decisions really crystallized the proposed hypothesis of a need for two-way communication and negotiated health care decisions.

Theoretical sampling helped us move toward theoretical saturation and to develop the linkages between categories regarding the selection of a sensitive physician. The negative case study from our oldest participant and her interactions with the cardiologist began to demonstrate the importance of the physician-patient relationship, and how good communication works between an elderly woman and her doctor. The need to participate in health care decisions in consultation with the physician was now the connection that glued all the layers together. Revisions occurred at all levels of the project throughout the process which included the ongoing interviews, document analysis (i.e., letters, copies of medical records, and e-mails), and typed transcripts. The field notes allowed for comparisons to occur between the spoken word and actions. Charmaz (2006) mentions the importance of comparisons between field notes and written documents, which can spark insights about the relative congruence between word and deed. We felt strongly that reviewing the letters sent by the elderly women, their copies of their medical records, and some e-mail correspondence was a way to verify many of the claims they had made about the interactions that had or were having with their physicians. Memos that were made during the analysis helped to provide further connections from conceptual labels to categories. Memo writing was that initial step forward from data collection to the writing of a series of rough drafts of the theoretical connections. The memos represent the earliest form of data analysis.

3/25/07 Memo regarding parent code negative physician/patient relationship

1. Another story was related regarding the lack of concern for this participant's desire to have knee surgery and convalesce at the facility.
2. The participant is articulate and also uses the Internet to search for alternative medical therapies for her knee. It seems unlikely that she

isn't able to contribute useful information to her diagnosis and treatment.
3. What is going on that this participant like the previous is searching for a new physician who is willing to discuss alternative treatments?
4. She does seem limited to searching for a physician that either comes to the facility or a short drive however the importance seems to be getting a chance to discuss all the possible options that are possible given her condition.
5. Perhaps this is not so much about finding a new physician that can be trusted as it is about dialogue that is participatory?

As the analysis was concluding, it became apparent that related issues of transportation and deteriorating health conditions had contributed to a need for improved patient-physician interactions. The ongoing analysis that was done in the final stages of this project helped to unite these phenomenon and incidents under an overarching hypothesis dubbed, E*lderly women* desire two-way communication and negotiated health care decisions with their *physician.*

Conclusions and Future Considerations

This study utilized a grounded theory strategy, which was used to assist in documenting the need for two-way communication between these elderly women and their physicians (Glaser, 2001). Often, grounded theory is criticized as being merely descriptive, and should instead provide a conceptual understanding of the problem which is both analytical and abstract (Charmaz, 2006). I believe that this inquiry provided more than a description of these elderly women's problems with finding a physician that was supportive and communicative. The proposed hypothesis is based on categories of coding that center on actions or behaviors related to finding physicians who provide two-way communication. Seeking health care for both chronic and acute conditions pushes patients into seeking advice from a physician. Transportation, emotional support, and the urgency of their deteriorating health combined to push these elderly women to seek medical advice. Since driving alone was often not possible, these elderly women felt it was difficult to locate a new physician. Public transportation options were available but most of the elderly women expressed having little to no experience using it and were fearful of the bus and taxi services provided by the city. Regardless of this urgency, these women wanted to retain some control over the decisions that are being made. Their desire to engage in a negotiated form of health care with their physician is a concept which can be used both now and in the future for these women and requires an opportunity to engage in mutual decision-making.

Even though these experiences are limited to these elderly women living in these assisted living communities, it needs to be investigated further to determine how this resonates with other elderly women. These unique experiences could be pointing to a larger phenomenon and continued research into this area will help to determine how viable our findings are with other elderly women. This proposed hypothesis reaches up from the categories and also connects downward to demonstrate the interrelationships of seeking medical advice given the issues of emotional support, deteriorating health, and

limited transportation. Mutual decision-making between the patient and physician has been advocated. Challenges with this kind of interaction center around the increased time it takes for physicians and patients' inexperienced in making health care decisions (Towle, 1999). These kinds of observations seem counter-productive to fostering the kind of collaborative relationships that the elderly women in this study had hoped to establish. It is important to note that helping physicians and elderly women to maximize their visit time provides discussion and fosters two-way communication leading to negotiation of health care decisions.

We would argue that although this style of interaction has been discussed, it hasn't been fully described or related to the lived experience of elderly women. It has been stated that mutual decision making might be obtainable with a shift in the delivery of United States health care to "patient-centered" care (Berry, Seiders, & Wilder, 2003). This approach has been posed as a way to address appropriateness, preference, and timeliness. Although this style of interaction appears to be a more collaborative, two-way communication provides a way for the physician to more expediently provide care. Rather than having elderly women making multiple appointments with a variety of physicians, the collaborative physician helps to reduce the increasing visit charges placed on the United States Medicare system. One visit may be more lengthy and participatory, but it reduces the need to make multiple office visits and associated charges.

The need to address deteriorating health among our elderly women is juxtaposed against the need for transportation to the physicians' office, resulting in elevated levels of stress for the elderly woman. Forming a list of items that needed to be addressed was a common method that the participants used when they attended an appointment helping to insure that each visit was maximized. Dissatisfaction occurred when the list of issues was not completely addressed, or if the elderly woman was unable to get feedback from her physician. Each of the participants wanted to have the ability to enter into a negotiation with her physician on treatment options. In some cases, the elderly woman had taken another woman to the physician's appointment to provide an "extra set of ears." This resulted due to the physician providing only a one-way style of communication. The elderly women struggled to adapt to this form of communication, resulting in a decision to leave the physician's practice. The difficulty in communicating runs from having no voice to struggling to inject their opinion. Regardless of the amount of input that is put forward, this one-way form of communication creates a barrier to making appropriate, preferred, and timely decisions based on their health care options.

Mutuality is characterized by the physician and the patient bringing recognized strengths to a relationship. With each party treated equally, the power is a bit more balanced between the physician and the elderly women (McWhinney, 1988, 1989). A study has been conducted on the blatant communication differences displayed by male physicians toward their female patients regarding mental health issues (Lurie et al., 1993). The current study did not generate information indicating a gender bias by the physician, since participants had difficulties with both male and female physicians. Many of our participants expressed having had varied experiences with both genders. The aforementioned research conducted with women regarding preventative health care did demonstrate better participation of women who utilized female physicians (Lurie et al.). So this may be an important factor that deserves continued research to determine its potential effect.

Some strategies have been proposed by researchers in this area to assist with the interpreted level of the patient-physician interaction. First, it has been suggested that strategies which are more on a negotiated level allow for open exploration with the patient, promote genuine expressions of empathy from the physician, and foster brain storming as to alternative forms of care (Bergman & Kandel, 2003). It has also been suggested that after the visit, a physician should develop a plan for ongoing communication. This requires obtaining permission and encouraging the patient to call and discuss any points of confusion about their care (Quill, 1983). Efforts are needed and continued research must be pursued to better inform physicians on the needs of women and their right to enter into a dialogic decision making process concerning their health care.

Limitations of the research include lack of diversity in the small number of participants in only two communities that were able to participate in the study. Replicating this work would be advocated with a more diverse group of elderly women that could contribute their experiences with communication and decision making in consultation with their physician. An additional issue for this study was the inability of these elderly women to recall some of their past experiences with great detail.

This type of research is needed to inform multiple levels of the health care delivery system. The translational influence that this could have on the education of medical students is profound and needs to be stressed in order for it to have the necessary impact on the health care system. Elderly women are also in need of being empowered to make decisions that influence their health so the timeliness of this type of research is paramount. Continued studies are needed to determine how negotiated health care discussions can be fostered between physicians and their elderly female patients. It will be important to explore this theory with younger women and also determine an effect that gender or age of a physician has on engaging in negotiated health care decisions.

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