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A council of elders: creating a multi-voiced dialogue in a community of care

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Abstract

In an era of ‘medical care delivery systems’, there is an increasing need for the patient’s voice to be heard, for it to be invited, listened to, and taken seriously. This challenge is particularly evident in geriatrics education, a domain of clinical training in which educators and clinicians alike must struggle to overcome adverse attitudes towards the elderly (‘ageism’). In this paper we introduce a ‘Council of Elders’ as an educational innovation in which we invited community elders to function as our ‘Senior Faculty’, to whom medical residents present their challenging and heart-felt dilemmas in caring for elder patients. In the conversations that ensue, the elders come to function not simply as teachers, but collaborators in a process in which doctors, researchers, and elders together create a community of resources, capable of identifying novel ways to overcome health-related difficulties which might not have been apparent to either group separately. Using the first meeting of the Council as an exemplar, we describe and discuss the special nature of such meetings and also the special preparations required to build a dialogic relationship between participants from very different worlds — different generations, different cultures (including the professional culture and the world of lived experience). Meetings with the council have become a required part of the primary care residency program — a very different kind of ‘challenging case conference’ in which moral dilemmas can be presented, discussed and reflected upon. It is not so much that elders give good advice in their responses — although they often do — as that they provide life world and value orientation as young residents gain a better sense of the elder’s experience and what matters most to them. This project has been particularly worthwhile in addressing the problem of ageism — a way to render visible stereotypes and adverse physician values, with implications for decision-making *with* the patient, not *for* the patient. © 2000 Elsevier Science Ltd. All rights reserved.

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As a resident you're so used to seeing some 80-90 year olds coming into the hospital or nursing home. So many of them are demented and you are unable to communicate with them. And you feel this very strong sense of, sort of hopelessness. It was wonderful for me to see these 80-90 year olds who are living in their homes, and are active, and they tell you all these wonderful stories about what they've seen and what they've done. (Second year resident)

It's so unusual... it forces us to look at them as vibrant and alive rather than as fragile, end of the line people that need our help. (Chief of Family Medicine)

Most of what we teach is how to take care of sick people; we know how to do that. What we don't know, what we don't do so well is give residents an opportunity to see how healthy elders live their lives, to be aware of what allows old people to function well. Only *you* can teach them that! And that is very important for them to learn. (Chief of Medicine)

It is unusual for health care professionals and trainees to be able to have a closely engaged dialogue with the people for whom they care. It is even more unusual for all involved to express their own worries and concerns to one other, and for community elders to offer teachings from their own lived experience and wisdom — and furthermore, for them to do this before an audience of other health-care professionals. But if they are enabled to meet in this way, with trainees being able to ask the elders for advice about current clinical dilemmas they are struggling with, some quite surprising results emerge. For, besides the specific advice offered by the elders, which may or may not be of help, they exhibit along the way many other aspects of their world — how it looks to them from within their living of it.

There is much in current medical practice which impedes the fostering and development of patient-centered medicine and relationship-centered care (Charon, 1992, Inui, 1996 and Laine and Davidoff, 1996). Recently, Donnelly (1997) has outlined a number of language maladies which work in the recording of case histories “to derogate, obscure, or simply to ignore the person of the patient” (p. 1046), and he makes recommendations for their remedy. In an era of ‘medical care delivery systems’, there is an increasing need for the patient's voice to be heard, for it to be invited, listened to, and taken seriously. Dialogue becomes a ‘core clinical skill’ (Duffy, 1995) and processes of care are more likely to reflect patient preferences and values rather than be driven solely by technological concerns. This challenge is particularly evident in geriatrics educa-

tion, a domain of clinical training in which educators must struggle to overcome adverse attitudes towards the elderly (‘ageism’): where elders are stereotyped as diminished and childlike in their capacities, afflicted by irreparable conditions, in need of assistance and ‘physicians’ orders.’ Indeed, we as educators may actually help create and perpetuate this bias in trainees: some of their earliest and most intense training experiences are hospital based, treating the elderly when most ill and disabled, when most impaired. More than the person of the patient is at issue, however but what is at stake for each in an emerging moral discourse. Two very different worlds — the world of the sick, aged and disabled, with their worries and concerns, and their local ecology, and the world of medicine, with the treatments and forms of care it can offer, but with its own worries and respective concerns — must in some way be brought into intelligible contact with each other, if a fully relationship-centered medical practice is to be realized (Katz and Shotter, 1996)¹.

In this paper we would like to describe an approach to primary care residency training which celebrates the ‘voice’ of community elders — the patient as teacher — which has important implications for care, training and research as well as answerability to our community. A ‘Council of Elders’ was established as part of a community health care project to help young physicians and nurses better orient themselves toward the treatment of older people — as well as some of the special preparations that made such a meeting between the old and young, the lay and the professional, possible at all. It was created as part of a geriatrics rotation in a primary care residency program and consisted of four elders, three women and a man, with a combined age and collective wisdom of 360 years — two of the women were 100 years old at the time of the meeting²!

In what follows, we will (1) first show how Dr. J., one of the first young residents to participate in the program, presented her case and the dilemma it faced her with in such a way that it fully engaged the attention of the Council of Elders — a presentation rather different from the usual medical format. Next, (2) we will outline some responses by the elders to her presentation. (3) We will then present some of the reactions to her encounter with the elders, both by Dr. J. herself and by others who were either present at the

¹ We have written elsewhere (Katz and Shotter, 1996) of the practice of a ‘social poetics’ in residency training as a way to invite the ‘voice’ of the patient, which renders visible resources not otherwise noticed in clinical practice.

² One of our Senior Faculty members died within the last year and a half, which provided the opportunity for meaningful discussion among all concerned, *e.g.* how elders carry on, what it means to be bereaved.

meeting or who later viewed a videotaped record of it — their comments on what they had gained from being present or otherwise witnessing this encounter are especially instructive: in particular, we will outline their implications for a form of ‘differential diagnosis’ especially sensitive to a patient’s world. (4) We will then present some preliminary data on the project, as well as some follow-up data including both reactions to the council offered some fourteen months after its first public meeting, and on developments over the last two and a half years of the project, to show the ‘depth’ of its effects, in regard to relationship-centered care. Along the way, we will make especial mention of the kind of preparations that made such a meeting possible, the preparations among both the elders and the young residents. (5) Finally, we will offer concluding remarks and implications for clinical practice — resourceful reminders for care and training.

How to present the case?

This 76 year old dementing woman with hypertension, depression, whose husband is ? abusive...

I’d like your advice about someone who is very special to me...

Two very different beginnings, two very different introductions into two very different ‘worlds’; two different ways of describing what could be the same elderly woman, the same case. One account belongs to the world of the academy and professional medicine, the other to the local world of community elders. One occurs in a hierarchical presentation to peers and senior clinicians, the other in a presentation to very different senior faculty; one in the language of medicine, the other in the ordinary language of lived experience. The first assumes a stance built on a ‘god’s eye’ view of a single world, the world of science, the other involves entering into a number of different everyday life ‘worlds’. One risks a fixity and narrowing of attention to a single order of connectedness; the other requires a particular kind of attentiveness, shifting and navigating between what is at stake for each of the ‘cultures’ present. Each stance leads to a different kind of answerability as well as a professional accountability, not just an accountability to one’s colleagues but to the community we serve, and a concern to be true to one’s world. As we will demonstrate below, what emerges in navigating these different ‘cultures’ is an attentive answerability: participants exhibit a practical responsiveness in their replies to each other, a sense of what is at stake for each in the local moral world (Kleinman, 1995) emerging between them.

The degree of attentive engagement by all concerned became apparent from the moment Dr. J. began her presentation to the elders. She faced the task of presenting to them the particular concerns she was struggling with in how best to help one of her patients, an elderly woman whom we will call Mrs. B. After having said that she would like their advice about “someone who is very special to me... and whose memory is failing her”, the resident went on to express her relation to her patient, Mrs. B., as follows:

The thing that is so wonderful about her, and that shines through so brightly, is her personality: she can light up a room. The thing that makes it difficult for her as well is although her memory is failing her, her body is very much intact.

Her husband now “treats her like a baby, which makes her wonder how she could go on”. And then Dr. J. wondered out loud to the elders as to how she should approach this situation as a young person: could the elders give her a sense of what it would be like in their lived experience to navigate such issues, what would be at stake for them?

This is a very different set of questions than physicians are taught to ask as part of their traditional academic training, whether in thinking about a diagnosis, or in presenting a case in a formal conference with their peers. The vocabulary is drawn from a different world to the world of medicine. More typically in formal presentations there is an emphasis on presenting objective data, the ‘facts’, in order to make hypotheses leading to a medical diagnosis and a proposed treatment, and in the process, look for a particular sort of evidence to back up decisions and conclusions. But instead of presenting Mrs. B. as a typical case of geriatrics in primary care, *i.e.* as a woman with Alzheimer’s with a husband suffering from care-giver stress, and how this constricted scene could give rise to abuse, she presented the particularities of Mrs. B.’s life. She used vivid images poetically expressed. This allowed the elders to engage with Mrs. B.’s world, to ‘enter into’ it. This kind of ordinary, everyday talk of detail also, is what enabled Dr. J. to participate in a living dialogue with the Council of Elders about her dilemmas in treating Mrs. B. By engaging the attention of the elders in this way, in the presence of her peers and seniors, Dr. J. did not leave behind or put aside the professional world, but new opportunities emerged. It led not only to the asking of different questions, but to a different way of asking them, to a way which ‘called out’ living responses from those addressed by them, words they could easily relate to.

Dr. J.’s everyday way of talking here was not accidental. In preparing with one of us [AMK] for her pre-

sensation the idea came up that she talk in such a way as 'to paint a picture' of Mrs. B., and of Dr. J.'s worries about her. In so doing, she helped the elders create a vivid sense also of her dilemma. (Indeed, as we will show in a later section, the elders continued to ask after Mrs. B.'s health even a year later.) When your utterances are about what matters to you, when you speak from your heart, you are necessarily centered in, and involve others in, the realm of lived experience and human values. And, in reflections afterward with AMK on her way of talking, this became clear in the following comments Dr. J. offered:

Dr. J.: "...we put a lot of thought into how I was going to say what I was going to say... I think it's just different".

AMK: "...was there anything that you were struck by about that process?"

Dr. J.: "I think the thing that was striking to me was that it was important for me to find words that were going to be acceptable to them, that they would understand and be able to relate to, ... words that I, my colleagues would be able to relate to — not even medical colleagues but just my peers, just because of generational differences, and what the impact, of... having an abusive husband... what that would mean to them compared to what it meant to me. So, I'm seeing that, I'm sort of not quite myself because I'm trying to really choose my words in a way that I hope will help them,... won't offend them, won't push them to a place where they don't understand what I'm trying to say".

This resident describes her experience of the kind of preparation needed to have a dialogue among people from very diverse 'worlds' — the cultures of old people, young doctors and senior faculty. She articulates the complexity of navigating these multiple discourses and what matters to each, which creates a different sense of herself — a need to shift back and forth. Her primary answerability is to the person she is caring for but she is still accountable to other persons and colleagues when she leaves the room. In an ordinary situation there is no need to search for words — she is describing how we switch codes and discourses and have available varieties of descriptions.

Indeed, in her account of Mrs. B. and in the questions she asked of the elders, Dr. J. did not hide her dilemmas in relating to her in any way. She exhibited them vividly and directly by formulating her question to the elders as follows:

I guess when I come to you and what would be really wonderful if I could have help in dealing with Mrs. B. is, I fear my youth and my inexperience

with some of these issues, will make it more difficult for me to anticipate how to help her. So I think if she decides to stay with her husband, who gets so frustrated with her and she's so frustrated with him, what kinds of things should I anticipate and how best would it be best for me to help her? And as well, if she makes the decision to go into a rest home, how would I best be able to help her?

The Council of Elders

An idea would be to have the young doctors come to one of our meetings, and they could look us over, and they would see that we have something to say. (Mrs. J., 100 years old)

Listening is a great expression of love. (Mrs. F., 100 years old)

Dr. J. was a medical resident in the community-based, interdisciplinary training program that is part of a geriatrics rotation in primary care at the Cambridge Health Alliance (CHA). This program was initially created as part of a larger initiative at Harvard Medical School to enhance the training of future physicians to respond to the challenges of the ageing of our population³. The Council of Elders was formed in collaboration with the Medical Director of our local Senior Center, a primary care physician, [LC] who asked his own patients if they would help us in establishing such a council to offer their advice and wisdom on our dilemmas in the care of elders. It is important to emphasize that as members of the Council of Elders, they were there as our 'Senior Faculty', not as patients.

Prior to the formation of the council, we [LC and AK] talked of what mattered to each of us — our shared values in patients being our best teachers — and about what kind of questions it would be good to ask the elders. We then went on to discuss which elders to invite⁴ and how to approach them with the project of

³ We are grateful to acknowledge The John A. Hartford Foundation, NY, for its support of the Harvard-Hartford Geriatrics in Primary Care Initiative (Inui and Wei, PIs) of which the Cambridge Health Alliance was a dissemination site. Currently, the continuation of the Council of Elders Project is supported (in part) by the Fetzer Institute.

⁴ The basic criteria for selection included: (1) a mix of gender, race and class; (2) no significant cognitive deficit (no formal MMSE was conducted); and (3) experience with enduring chronic illness(es) and prior hospitalizations (know what it means to be a patient and care-giver). Based on the primary care physician's relationship with and knowledge of the individuals concerned, we discussed other less tangible but no less important features, such as, our sense of their 'fit' with the others in the group, their wisdom, and that they would have a lot to teach us.

becoming our teachers. One of us [AMK] then began to meet with the elders individually, before we all — AMK, LC, and the elders — met together as a group. A special sense of comfort was built up within the group by our inviting LC's patients to reflect on the practice of medicine, through him reflecting on his practice of care with them. This, of course, reversed the usual hierarchy. Without needing explicitly to explain the new rules of engagement, by our very adoption of this new way of addressing ourselves to them, we adopted a position more on a level with theirs, and implicitly invited them also to do the same. Through these practices, all concerned came to perceive each other 'without rank' (Bakhtin, 1986, p.97). Although unused to speaking with professionals in 'official' environments, this more intimate way of speaking with them invited their voice — and such engagement created a situation within which their contributions made sense and mattered. The transition to the full, public meeting, although not without its tensions and anxieties for all concerned, entailed the maintaining of this form of inter-relating.

Now accustomed to this way of relating to physicians and other professionals, the members of the council listened with rapt attention to Dr. J.'s presentation of her case. Clearly, we do not have the space here to present a full transcript of the elders' responses. Something of their flavor can be captured however, in the following list of initial remarks offered:

Mrs. F. (100 years old): uses a spiritual metaphor, and emphasizes the healing effect of 'helping others': "...when you can't think of people's names and you're worried about yourself, if you start thinking about somebody else... your own little difficulties don't seem very important. ...And if she feels like going to a rest home, she would soon find there were plenty of neighbors there that she could be companion to. *And that is a great resource...*" She also pauses and adds, "I don't know about breaking up a marriage..."

Mrs. N. (82 years old) says, she would move to an "apartment of my own"... "I'd break up with him in a minute... You'd better believe it. If he *ridiculed* me once too often..." Because she's worked in a nursing home for 'many years' she is explicit about their advantages (many activities) but also clear that they do not represent a personal home.

Mrs. J.: (100 years old): "Well I was just thinking, perhaps if the lady made a change, like to go into a place like we are, a Senior place, it's very different, very active. And there's very *many nice people there to help you...*" Her comments precipitate group talk

about the patient's remarkable love for singing and dancing.

Mr. P. (78 years old): "...sometimes people become off kilter, lackadaisical because what they get accustomed to dissipates. They don't have it to do anymore; it goes down. And they just stay like that [slumps over]... You gotta give her something to do. You give her a job. Give her something for tomorrow or next week. And then, when she misses, (and you know she'll miss), you bawl her out gently". In this way "*...you became important even to yourself and your doctor...*"

Each offers something different, perhaps hearing each other they made a creative effort to think of something else, a different perspective. Indeed, a striking feature of the Council of Elders rejoinders, was the extraordinary degree to which the elders contextualized, reframed and offered insights into the meanings embedded in the courses of action the clinicians and older couple might take.

As the meeting continued, others in the audience resonated with their own reflections and heartfelt dilemmas, as they also pondered possible courses of action. For instance, one of the doctors in the program asked the elders the following question:

Dr. A: "I'm one of the doctors in our program, who has interest in, in these issues... I wonder if it were my patient, how could I help this woman to seek her independence if she's apparently fearful? What kind of advice would you give to her not to be fearful at this stage in her life?"

Mrs. N: "Well, it's kind of hard to tell a person to leave her husband; that's not what I'm trying to say. She's probably in love with her husband. Get them both into one of the Senior places. And then they'd have activities for both of them..."

While another asked for advice on what we should do about her husband,

Mr. P: "That could be part of the problem too. She doesn't feel compensated for the effort she is putting in. And then she reach a point where she doesn't care what she do. People are like that. That's where you come in. You got to convince her it's not that way. And you got to convince him that he is wrong. You got a big job!"

All present were engaged and listened intently as one by one the elders expressed their views. And clearly, much more was heard (and learnt) by those in the audience — and by those later viewing the videotape of the meeting — than merely the elders' answers to the questions they were asked. The dialogue forum shifted

beyond a culture of mere question and answer aimed at reaching a consensus among experts, and became a meeting of different worlds. Next, we turn to reactions which exhibit this.

What was learned from the council?

After the meeting, AMK talked with Dr. J on her reactions to her experiences. Focus groups were conducted with those who had been present at the meeting, as well as with those viewing the videotape who had not been able to attend. Comments reflecting on what was shown in the meeting about the elders' world were both interesting and sometimes surprising. We will turn first to Dr. J.'s comments to AMK:

Dr. J.: "I remember like there's a transition point where I started to feel more comfortable, like that we were just sort of talking, and could block other people out. [I] also remember when he [the elder, Mr. P.] said, "Oh, she has Alzheimer's". And I thought, he's medicalizing it, and how much of it is, choosing words that they would know, and what it means — you know, Alzheimer's is, a medical term that would mean more to them than some other medical term because... they're acutely aware of that... It's just a lot about language but, let's see — It's fun".

AMK: "It's interesting; it becomes a dialogue —"

Dr. J.: "— Right —"

AMK: "— once they put a word out on the table you can follow it —"

V.: "— Right —"

AMK: "— and ask them what they have found it to mean which may be different than what you [might expect]..."

What was helpful about the interaction with the elders? And what gets carried into practice? Thinking back to her original dilemma about Mrs. B., Dr. J. felt a kind of support from the elders on many levels: "They validated for me the very personal part of what I was trying to do with her, as well as 'helping her to feel good about herself,... be with her where she needed to be'". Further, she was 'struck by', both the quality of engagement and its implications...

Dr. J.: "...they are these wise elders... like when she [Mrs. F.] says 'just listening is such a great gift'. And all these things that — It just, it slows you down, it slows you down terribly, sort of, to think about what's important, and just reframes all these medical interactions we have... We can be really

hard on ourselves as physicians sometimes about what, how to make things okay, and what to do, and it's just not enough..."

Many of the issues raised by Dr. J. were also mentioned by those in the audience for the meeting, by those only able to watch a videotape of it later, and by those who later presented their own dilemmas at other council meetings. In a focus group with some of the residents in the program who had been in the audience, the first comment offered reflected the striking contrast between the elders in the council and the old people usually encountered in hospitals:

Resident 1: "...the age of some of them was just remarkable: some of the people were in their early 90s and a few people were 100, and very articulate... in the hospital setting... we see elderly patients who are pretty debilitated, often times demented and diseased. [But here, we saw] people in the community that are 'old-old'... and are really 'with it'. It's really enlightening."

Other residents in the program commented on how, often, they had a sense of hopelessness about the elderly they encountered [as patients], and to see such old people alert and with so many faculties still intact "was wonderful" — clearly, their previously somewhat fixed viewpoint was a burden to them. Further, the diversity amongst the old was emphasized:

Resident 2: "The other things that was really interesting was the take-home message that elderly people are not more homogeneous as a group than any other. There was quite a diversity of opinion among them, members of the group, and I think it is really useful to show clinicians in training that this is the case..."

Resident 3: "It would be a great example to have an Elder Board of Hindu, or just a multicultural Elder Board; I think it would be a great idea to combine people of different cultures".

One of us [TI] was particularly struck by the videotape and went on to use it in his teaching. To him, the most striking feature of the Council of Elders dialogue, was their extraordinary capacity to contextualize, reframe, and offer insight into the meanings embedded in whatever courses of action they suggested clinicians and the elder couple might take. The contexts of meaning articulated by the elders are remarkably rich: faith, work, friendship, abiding talents, assumption of responsibility, options for refreshing or safely "breaking up" a marriage, taking special care of love, were all at one time or another considered. All of these are perspectives from which one could frame a proposed

action. All contexts are sources of value which may be especially important to consider before devising plans of action, or when accommodating oneself to a new circumstance that flows from actions taken. All these perspectives, as they are articulated by the elders themselves, may be marginal considerations or at the center of clinician-patient conversations before and after a plan is initiated. As a group, the Council of Elders does not strive to prescribe a particular, consensus plan of action. Not one of them suggested that the others' points of view are misbegotten or inadequate in any sense. All of them seem to be offering useful alternatives. Together, they end by emphasizing the need for sensitive action and tailoring to the unique circumstances or individual. As Mr. P. said, "You can't put any set case or any set formula on any given person. But you try what you have at hand. And if that don't work, you try something else". About this, the clinician above continued:

As a clinician, I found the points of view that emerged to be compelling, each in its own right. It also was helpful to understand the diversity of perspectives that might be at work, essentially a 'differential diagnosis' for the value orientation from which the patient, family, and I could approach the problem at hand. Finally, it seemed to me that initiating the dialogue by saying out loud, and clearly, that we (clinicians) don't know what to do, may have created space and permission to emphasize very personal perspectives and experience, greatly enriching the options articulated and permitting the elders' substantial real experience to be exchanged openly, even in this quasi-public setting.

In other words, what is being proposed here is a kind of 'differential diagnosis' which takes into account the many different value orientations — of the patient, their family, the physician and other health-care professionals — relevant in arriving at a caring treatment.

Later reflections and developments

Fourteen months later

The leadership team met with the Council of Elders to reflect on the project from each of our perspectives — as physicians, nurse-practitioners, residents, with the community elders themselves. We talked of what we each now found as most striking, how it has effected our practices, and how we would like to continue on with the project.

One of the first to arrive was the resident Dr. J., who had presented her clinical dilemma and she was met with a series of heartfelt questions about Mrs. B. from the elders themselves: "how is Mrs. B., did she go to a nursing home"? How is her husband; does she get to

see him'?" And one 101 year old added, "I can't tell you how many nights I thought of her, how is she doing? Is she back with her husband?" In listening to her level of concern, one of the MDs said, "We didn't mean to burden you". Perhaps, the point was not so much that she was 'burdened', but that relative strangers could have so influenced each other's lives — they become a part of each other's responsive community.

The Chief of Medicine then talked of being struck by the range of responses of the elders, the advice they offered us about what would be helpful to them: (1) giving them something to do (from putting stamps on envelopes to holding babies in a pediatric nursery), (2) pointing to some of the challenges they face to being out and about in the world, like problems of access and transportation. And he continued, that in his position most of what he sees in training doctors are the dilemmas they face in caring for sick people: "Most of what we teach is how to take care of sick people; we know how to do that. What we don't know, what we don't do so well is give residents an opportunity to see how healthy elders live their lives, to be aware of what allows old people to function well. Only you can teach them that! And that is very important for them to learn". And in resonating to being responded to in such a way, the elders immediately carried the discussion one step further, and began to suggest ways they themselves could help. "OK", says Mrs. F., "next time I come I could pick up others who have a hard time getting here"

A nurse-practitioner began by complimenting the elders for being really excellent teachers: She was particularly struck by the quiet, attentive atmosphere in the room: when they were speaking:

You could hear a pin drop. And that's not usually the case with our usual teaching sessions... what you were saying was really coming from your heart. And I think we don't teach that way enough. Everybody that was there was really struck by being someplace where something very important was happening. And I think that was part of it. ...I've been caring for older people since I was, I guess 25. And I can tell that as I get older, over the 20 years, I understand what it means to be old a little bit more each day. But I think I still don't understand what it's like to be 80 or 100. So it's very helpful for me to listen to you so that what I'm hearing from people who are older, I feel like I can see the world through, in that way a little better. So it's very helpful for me personally. ...I was struck by how much it meant to all the people in the room.

In terms of how it has effected her practice, she paused and said, "I think it touched on the way we

want to practice and how we want to talk about patients and problems, and our own thoughts. But we're not really able to do that enough. ...we were able to do that when you were teaching us. And we were all very moved by that, at least I was very moved by that". This stayed with her, and later she commented: "I was so struck by Mrs. J., here she is 101, and her reaction always is 'yes, I need to work on that; I would like to learn more about that, or I could do that better'. I don't even have that reaction at my age".

Another physician talked about the profound impact this meeting had on him, as he was struck by the importance of communication with elders as being a two-way process.

I talk to old people all the time, my patients, my relatives, I love it. But what I became aware of in this meeting was how much it can be only one-way. Here we are expecting them to talk to us about intimate aspects of their lives, what matters to them — and they don't know anything about us! I was initially a bit taken aback when I came into the meeting and one 101 year-old said, "where are you from?" And I found myself thinking "this is inappropriate", but, no, we are the ones who are being inappropriate. So what I am taking away is that it must be two-way.

They all agreed to continue to meet. "We learn so much from each other", said doctors, nurses, residents, researchers and elders alike.

Further developments

Although this paper has been organized around a single case presentation, meeting with the Council of Elders has not been a one-time event. It is now one year later and preparation and presentation of dilemmas to the council such as the one described, has become a required part of a month long geriatrics rotation for second year residents in the primary care residency program. This has come to be thought of as a very different kind of 'challenging case conference' in which moral dilemmas and quandaries can be presented, discussed and reflected upon with the elders, residents and faculty alike. At CHA we are considering using the same methods for other patient populations whose care is hampered by stereotyping: *e.g.* patients with addictions and with psychiatric disorders. Since the writing of this paper, eight residents and one nurse practitioner student have presented to the Council of Elders, and the project (including videotapes of the meetings) has been presented locally and nationally to audiences over the life cycle of physicians, from medical students to residents to senior clinicians, as well as to other groups of community elders. There is interest

in at least two other academic institutions in developing a Council of Elders. As we describe in our concluding remarks below, this project has been particularly worthwhile in addressing the domain of ageism — a way to render visible stereotypes and adverse physician values, with implications for decision-making *with* patients and their families.

Concluding remarks: resourceful reminders for practice

From case presentation to entering into two very different 'worlds'

The meeting with the council was neither an 'ordinary conversation' nor a typical academic case conference — but the development of a new dialogic forum, answerable to the community. It gives rise to the creation of a local moral world where each (community elders and professionals alike) can talk of what is at stake for them. On the surface it appears to be a meeting of 'strangers' and indeed in one sense it is. But in other ways, meeting with each other 'without rank' they are not at all strangers: they each talk of what matters most and in so doing, reveal aspects of their own unique 'life-worlds' to each other. This is crucial. By ignoring their own lived experience, elders can be made too familiar by expecting them to respond in predictable ways as representatives of established diagnostic categories. A kind of prejudicial intimacy, a set of expected responses, may arise from diagnoses, and come to determine what responses are legitimate and which, in fact, are left on the margins. Similarly, attitudes of 'ageism' may diminish the ability to attend to what is unique and resourceful about how older people live their lives. In the event, young doctors were sobered, and instead, noticed with surprise the diversity of responses of these community elders. Indeed, they were struck by the realization that they expected them to respond in stereotyped ways. They noticed that the elders made much more room for difference than they as doctors would normally allow each other in their search for consensus in their professional world.

Learning of this kind is not vague — it is not just the experience of talking to old people — it also fosters the ability to make more explicit what is carried over into practice, *e.g.* the dimensions on which to judge appropriate treatments, or aspects of the decision making process itself. Doctors gained not so much better information as a better orientation; they became aware that their usual stance was to interact with very sick patients in the hospital — what is not usually taught is how elders actually function in *their world*, what they can do and still want to do for themselves. This was

brought out by a geriatrician on his viewing of a videotaped record of the council. "What I'm struck by", he commented, "is the tension of recognizing someone has dementia and under-selling the patient's capability".

A special kind of listening

To pick up all the things that can be learned about the world of older people from being present at such a council as this, to hear all the things which are there but not explicitly said, you have to listen in a different way: not in the more familiar, technically oriented way, or critically as a disengaged evaluator, but *appreciatively*, to hear what elders have to say as more than merely an answer to a question, a solution to a problem, or an exemplar of a fixed category. One must listen imaginatively, in an attempt to enter into their lived experience from their utterances. This kind of seminal attentiveness is exemplified by Dr. J. in noticing that when one of the elders brought up 'Alzheimer's', it was suddenly both a familiar medicalized category, while also meaning different things to different people: she could then open up these meanings with the different participants in terms of their own experiences. The elders too have to learn how to talk freely, as themselves, in such a situation. Here, these ways of listening and talking were made possible by those involved learning an 'unofficial' way of engaging with each other, a way of relating to each other that the preparations with each group promoted.

Meeting the challenge of ageism — moving beyond stereotypes

With this kind of willingness to engage with strange 'others' on an equal footing, aspects of people's lives not explicitly talked about but clearly shown, or exhibited in the way in which they respond to their circumstances, become apparent to all. What is seen and heard does not fit into preconceived notions or stereotypes. In effect this engaged participation, in rendering stereotypes visible, works to open up new possibilities, new ways of going on with 'others' not before thought possible — because of the fixed ways in which they had previously been imagined. By everyone involved voicing what matters to them, and by exchanging their different views on each other's concerns, all become engaged in the process of making meanings together. Clinicians face the complexity and challenges of dealing with dementia, care-giver stress and potential abuse. While elders come to see something both of the world of medicine, the openings and barriers it offers for their benefit, and their doctors as persons, who are able to interweave ordinary human concerns into their more technical expertise. The domain of human values

thus emerges as each talks of what matters to them, and seeks to understand what is at stake for the other, with implications for the process of decision making.

Value of dialogue 'without rank'

With all involved meeting each other in this kind of dialogic or conversational forum, there is no push for an overarching coherence but instead, an appreciation of the different angles each has brought to bear on this present dilemma — a "plurality of unmerged consciousnesses" (Bakhtin, 1984, p. 9) emerges. Indeed, circumstances were created in which all concerned came to perceive each other "more or less outside the framework of social hierarchy,... 'without rank' as it were" (Bakhtin, 1986, p.97). We legitimize what the elders in the council say, we show that we take their sense of the shape of their own world seriously, both in our original invitation to them to be our teachers, and by how we play out that invitation in the respectful way in which we both speak with and listen to them in the meeting. Especially, we treat their everyday life world as a world of respect and importance by using *its* language, the language they speak — a language we can, without much effort, speak too. When these conditions hold, there is a vitality of engagement at work in how each participates in the dialogue, navigating difference and playing variations on a theme. And this measure of participation is generative, as those present now offer their own responses, again making room for further specification and elaboration. This is what we find compelling in being present at these meetings, or in watching the videotape afterwards: something is going on that we don't ordinarily expect.

In summary, in this study, through an initial case exemplar we outlined: (1) the special nature of the dialogic relationship between participants from very different worlds — different generations, different cultures (including the professional culture and the world of lived experience) (2) and, the special kind of listening and attentiveness engendered. These two together allow young physicians to 'enter into' a world unfamiliar to them and yet, make visible resources that would otherwise go unnoticed. Over the different council meetings, residents and faculty alike remarked on the effects that it has had on their practices, that it has altered how they see older people — they were suddenly 'struck by' the preconceptions and stereotypes that had led them previously to react in automatic ways. They went on to specify, articulate, and elaborate what was learned and carry over it over into practice. Rather than the fixity of hopelessness of the circumstances of elders, they talked of new possibilities for engagement: a resident remarked that he now carries the Council of Elders with him as a 'resourceful

reminder' of places to go in the old peoples' worlds. It has changed the way he practices medicine: "I wish I had them with me with every 65 year old who says there's nothing left to live for". It is as if with every new case he can imaginatively consult with them to create a landscape of possibilities against which to judge the appropriateness of his decisions. Indeed, he became intrigued by the very nature of the decision-making process itself — on what do elders base their decisions that we're not aware of that could be a resource, a basis for making decisions *with* patients, not *for* them (Katz, 1984). There is an important kind of transferability here: the resident can now carry across aspects of the elders' world(s) into new contexts.

We listen in wonder as each of the elders in turn speaks in his/her own unique way about the nature of the problem at hand. They have given a lot of thought about their role and want to help. They listen with great concentration on the cases presented to them. But the point here, is not so much whether their advice is to the point or not. What is crucial, is in what they say and how they say it. They are exhibiting something of what it is like to be old. And this is what is of use to young residents in learning how to orient themselves within an elder's world. For they need to know how to 'go on' within a world which has for them, a strange 'shape' to it. Thus the elders in the council should not be evaluated as *representatives* of a particular disease or demographic category, nor should they be declared as worthy of being 'authoritative experts'. But they play a critical role as dialogue partners in participating together with health-care professionals in addressing a real dilemma in care. For in calling on their lived experience and their wisdom, we can begin to see how each can contribute a piece to this process of collaborative meaning making. Thus, what is gained by participants in such a project as this is, not so much any new technical information, but orientation, a more clear sense of knowing 'where we are and what's happening', a sense of what can and cannot be done in caring for others, and of what they can still do in caring for themselves.

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