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Exploring the Experiences of Elderly African-Americans to Physician Supervised Pharmacologic Treatment

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ABSTRACT

Patients are expected to adhere to physician treatment recommendations. Noncompliance to prescription medication is however often problematic in the elderly for different reasons. The consequence of failure to follow medical treatment may lead to increased medical costs, hospitalizations, and even death. The elderly average 12.7 prescriptions per year, consume 30% of prescription medications, spend \$15 billion annually, and receive eight or more medications per day. This qualitative study involved a phenomenological design, as the aim was to explore pharmacological noncompliance by those under the treatment of a licensed medical practitioner. The participants included a purposeful sample of 20 elderly African Americans for this study, from the state of Wisconsin in the United States, drawn from the congregation of an inner-city Church. The open-ended nature of the questions facilitated participants to provide insights into a personal medical condition and deeper conversations associated with medication compliance. The normative decision-making theory served to underpin the study and aid acquiring a deeper understanding of the motivations that drive, or constrain compliance to medication. The analysis of the data took place after completion of the interviewing process. The interviews conducted were recorded, coded, transcribed, and categorized to facilitate the analysis of the data using an appropriate qualitative data analytical software program. The findings of the study drawn from an analysis of the interviews of patient, aided in gaining a deeper understanding of compliance to physician directives in pharmacologic treatment by participants in this study.

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Introduction

Background of the Study

The degree and extent a patient follows the advice and treatment of the caregiving physician, may determine better medical outcomes. Individuals when undergoing medical treatment may for different reasons, fail or refuse to take prescribed medications and follow the health care provider's treatment guidelines and directives, and this refusal or cessation may represent noncompliance. The underlying reasons for patient noncompliance with prescription drug therapy is often attributed to a lack of education, health illiteracy, memory impairments, or the inability to obtain medications because of financial constraints (Stewart, 2006; McCuaig et al., 2012). McLeod (2007) stated that the non-adherence to prescription medication by patients as recommended by a licensed medical practitioner is a growing social concern. Noncompliance by a patient to treatment and a prescribed drug regimen is often evident in conditions, such as chronic obstructive pulmonary disease (COPD), hypertension, diabetes, cancer, lupus, and joint bone diseases (DeWalt, Oberlander, Carey, & Roper, 2005; Peterson, 2011; Ward, Schiller, & Goodman, 2012).

The Milwaukee County Department of Health and Human Services (2010) found that African American's have a higher occurrence of high blood pressure, diabetes, lung cancer than Caucasians (National Center for Chronic Disease Prevention and Health Promotion 2009; The Office of Minority Health, 2012; National Institute of Health, 2012).

The possible lack in following a health care provider instructions and adhering to prescribed medication dosing schedules may help to identify aspects that influence compliance among the elderly African American patients (Healthy People, 2010). The breakdown of communication between health care professionals and patients, to follow up with the elderly prescribed medication may contribute to poor compliance, as the educational background of patients in the health care system is often an underlying reason for a failure to follow guidance (Bedell et al., 2000; De Forge, et al., 2006; Paul, 2008; American College of Preventive Medicine, 2011).

Problem Statement

Patient non-compliance has serious mortality consequences, with the United States Department of Health and Human Services (2007) report attributing 125,000 deaths to it. The increase mortality consequences strain the health care systems with hospitalization costs arising from adverse side effects, falls, hip injuries, fractures and other untoward consequences. The statistics of elderly patients with a high average of 12.7 prescriptions per year, and expenses incurred of \$15 billion annually, may reflect the need for medication compliance to offset hospitalization and other expenses in failing to follow treatment (Ayala et al., 2007; Vrijens et al., 2008).

The general problem is that noncompliance to physician pharmacologic and other treatment costs the United States taxpayer an estimated \$1,000 billion annually (Herrick, 2011).

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Patient noncompliance escalates treatment and hospitalization costs, and increases physical and financially debilitating injury and mortality outcomes (Chia et al., 2006; Vrijens et al., 2008). The specific problem is that the compliance by elderly African American patients to medical treatment is also little understood.

Purpose Statement

The goal of this phenomenological study was to understand challenges of elderly African American patients in adhering to a personal physician treatment and direction. According to the United States health care system (CDC, 2007) patient noncompliance often results in injury or death (Chia et al., 2006; Vrijens et al., 2008; Fiscella, & Holt, 2008; Fongwa, Evangelista, & Doering, 2006). The discoveries from this study may increase the understanding of clinicians about prescription medication compliance. The qualitative method with a phenomenological design for this study deemed appropriate as it represents an approach for deep inquiry and understanding a problem (Flood, 2010). The study was conducted in Wisconsin, in the United States, with purposeful selection of 20 African American individuals as participants. Repeat hospitalizations because of willful or negligent noncompliance with a medication regimen cost \$12 to \$15 billion yearly to taxpayers (Kenen, 2009). The findings from this research study could be helpful in discovering perceived barriers that may contribute to prescription noncompliance.

Table 1 below reflects the cost and impact of noncompliance in the health-care industry to the concerned stakeholders. The high costs as well as the mortality figures may convey the significance of the problem.

Table 1. Impact of Noncompliance in the Health-care Industry on Stakeholders.

Patient non-compliance consequences	Economic and mortality data	Referenced sources
1. Non-compliance may result in adverse side effects to medication self-dosing, such as loss of balance, falls, leading to hip injuries and hip fractures.	Costs \$20.2 billion annually and may cost \$34.2 billion by 2020	Ayala et al., (2007).
2. Lack of prescription medication compliance results in high annual costs to the United States taxpayers	Approximately \$100 billion	Smith, (2007).
3. Noncompliance to physician medical regimen is a known cause of mortality.	125,000 deaths occur per year	The United States Department of Health & Human Services (2007, p. 5).

Overarching Research Question

The overarching research question for the study was RQ: What knowledge of the lived experiences of elderly African American patients could foster improved physician strategies to enhance medication compliance?

An in-depth exploration of perceptions and lived experiences provided the rationale for qualitative research as the optimal methods for understanding the phenomenon and in advancing knowledge of strategies to enhance compliance.

Significance of Study

The aim of this study was to identify human challenges to noncompliance to prescription medication, as it often results in frequent re-hospitalizations, and strains the system and taxpayer. The findings of this study hence may be of value to medical practitioners and administrators. The lack of knowledge of elderly African Americans on health care issues is a concern with medication compliance (Sheridan, et al., 2011). Following the health care providers advice for medication management and through self-empowerment, the patient may learn more about a personal medical status and condition (Wallston, Wallston, & DeVellis, 1978; Gallo, 2010). For better medical care, it is critical that the elderly understand the rationale and importance for following the prescribed treatment and drug regimen. The elderly often need to understand the purpose of the medication, the possible side effects, and the reason for the imperativeness to comply with the prescription medication orders (Hixon, 2004; Christensen et al., 2010).

A study of non-compliance may be of importance and significance as this is an area that has implications that extend into the realm of patient welfare and the health-care system. The aim also included studying the negative consequences using mortality rates, adverse events, economic, financial, therapeutic, and examining and analyzing other relevant data and information (Johnston, Diab, Kim, & Kirshblum, 2005, as cited in Armstrong, 2007; McCuaig et al., 2012). According to the United States Inspector General's Office, Health Literacy Action Plan, (United States Department of Health Human Services, 2007), 125,000 deaths per year occur because of noncompliance to prescribed medications reasons include the fear of the inconvenience of side effects. The other reasons cited for noncompliance are attributed to lowered cognitive abilities include the inability of the elderly to understand instructions, alterations in their taste perception, and the denial of illness. The cost of medications and lack of insurance are economic situations that may exacerbate the problem (Schillinger, 2007).

Nature of Study

The rationale for selecting a qualitative method for this study was to discover and elicit rich descriptive data directly from participants. The study design represented an empirical phenomenological approach, which rested on the premise that learning takes place through lived experiences, and communication with study participants often facilitate a deeper understanding of a phenomenon under study (Moustakas, 1994). The nature of the problem in this study required a qualitative approach, which research experts have considered helpful when utilizing exploratory and interpretive research questions (Leedy & Ormrod, 2010). A phenomenological study served to gain insight into an individual's perspectives, perceptions, and understandings of a phenomenon (Moustakas, 1994; Neuman, 2003; Creswell, 2007; Leedy, & Ormrod, 2010; Tozer et al., 2014). This study entailed recording the interviews of participants, following with transcribing and analysis of the data generated in response to the questions asked during the interviews, using the appropriate qualitative data analytical software cited herein (QSR International, 2007).

Contribution of Knowledge

Understanding the keywords promoted knowledge and application of the approach in active research. The phenomenological approach facilitated deep conversations with participants and included in this study, measures in

mitigating personal researcher biases. The study findings are characteristic of the concepts of reliability and validity. An exploration of participant lived experiences focused on understanding how critical thinking (Moustakas, 1994). The aim of phenomenology was to capture patterns or themes from the elderly African American's lived experiences. The long-term results of using a qualitative approach included suitable steps and strategies within this study to enhance and derive benefits in quality arising from the consequent emphasis to infuse rigor, dependability, credibility, and transferability of the study's findings.

Theoretical Framework

Researchers, Kruglanski & Gigerenzer, (2011), concluded that most individuals used heuristics when deciding on risk and uncertainty. Heuristic thinking could lead to poor decision making because of the misperceptions of the risks. Similarly, the framing of the problem matters, for example if the emphasis on gains rather than losses, could affect the risk-taking propensity in a financially oriented study. Emotional states such as stress, fear, and a lack of connection with the problem could engender the use of suboptimal decision-making strategies. When individuals, or groups, have the resources of experience and expertise from which to draw from, they tend to make decisions in very different ways.

The study focus was to determine how participants comply with the medical directions recommended by health care practitioners, and may also shed light on how patients' health care literacy affects the health care locus of control (Bajcar, 2003; Christensen et al., 2010; Graham & Lavicka, 2010). Schillinger (2007) reported noncompliance negatively influences the elderly with chronic conditions and immunosuppressive disorders. Medical side effects often lead to elderly individuals to stopping their prescribed medication without consulting the attendant physician. McKenzie (2007) reported that the use of identifying those in need of compliance assistance before initiation of medication regimen was a good practice. The Folstein Mini-Mental Status Examination (MMSE) is a standard geriatric assessment tool that the participants in the study scored 19 upon the tallying of scores. One major problem with the MMSE tool is the reliability of measurement techniques of medication compliance, such as patient self-report, drug interactions or drug side effects (Schillinger & Vang, 2006; Depp, et al, 2011). In a study by Barat et al., (2001) on medication non-adherence among the elderly, 58% of the subjects receiving hypnotics, and 36% using analgesics were noncompliant, indicating the nature of the condition and the type of medication often play a role. Barat et al. stated that the number of prescriptions is a predictor of noncompliance in the elderly population. Physician(s) should evaluate the number of drugs the patient is taking per day, and whether the patient is living alone or has family support to follow through with compliance (Laufs, Rettig-Ewen, & Böhm, 2011).

Qualitative research entails exploring the behavior and perceptions concerning issues of participants with personal experience of a phenomenon. Qualitative researchers use a small group to guide and support the hypothesis, strive for descriptive insights; include in-depth interviews with group discussions or individuals guided using concepts, frameworks, and theories (Flood, 2010; Lapan et al., 2012). The aim of the study was to understand or gain insight into the lived experiences of elderly African-America patients regarding compliance with a prescribed medical treatment

plan. The research involved participants narrating personal life stories about managing a medical condition. The endeavor was to gain insight into the experiences and the lived experiences through the life stories of the participants (Kafle, 2011). A transcendental phenomenology, on the other hand, was not appropriate, as the aim was to gain an understanding of a phenomenon's general characteristics rather than the individual's experiences related to the process (Kafle, 2011).

Ethnography and a case study were also inappropriate for this study. Ethnography is a research study procedure used to describe, analyze and interpret the activities of the group of people (Creswell, 2005; Leedy & Ormrod, 2010; Tozer et al., 2014; Moustakas, 1994). A case study was also inappropriate for this study because the focus of the inquiry was to explore the elderly African American's perspectives and lived experiences to understand better the phenomenon, not to develop an in-depth understanding of a case. A qualitative phenomenological approach was found necessary after extensive research to select a design. A suitable design was required to explore and understand the phenomenon and gain first-hand information from the participants, and the rationale for phenomenology was based on careful consideration and analysis.

Epoché Process

Bass, (2009) discussed the importance of considering the validity and reliability of the research instrument. Salkind (2008) stated that reliability and validity are the first line of defense to protect the integrity of research and guard against incorrect conclusions. In the process of describing phenomenological research, steps have been suggested for the conduct of a phenomenological inquiry into accurate validity and reliability (Leedy & Ormrod, 2006), and such measures instituted served to ensure meet validity and reliability standards. The steps included bracketing, sensing, analyzing, and describing (Morse & Field, 2007). Using epoché or bracketing, keeping in mind the importance of internal and external validity as it pertained to valid and meaningful conclusions that have applicability and relevance beyond the specific research at hand. Creswell (2008) and Moustakas (1994, p.56) suggested that in the epoché or bracketing process, the researcher refrains from taking a position instead ascribes equal importance to every quality.

For this study, invoking the epoché or bracketing process involved putting aside personal experiences, feelings, values, judgments, attitudes, and beliefs regarding the relationship between leadership style and participants' commitments. To establish reliability and yield consistent results, we used a standard format for conducting the structured, and the audiotape interviews. Each interview questions followed a three-part format. The objective of the first part of the interview was to present opening remarks and obtain a response to one qualifying question. There was an explanation of the nature of the study and the participants' involvement in the study. Data saturation, determined by the reoccurrence of themes, occurred after conducting face-to-face interviews with 20 volunteers who met the prescribed selection criteria. The abundance of the data collected from participants led to the formation of composite descriptions of the noncompliance factors. Bracketing opinions and biases process included refraining from the standard approach that takes events from outside assessment; and replaces empirical phenomenology in its place and judgment from inside discernment (Klein & Kozlowski, 2006).

Using the bracketing strategy, we tried to examine events through an innovative perception, to revisit the experiences using abstaining from preconceptions, as suggest by researchers (Giorgi, 1997). Creswell (2008) and Moustakas (1994) stated that collecting data until data saturation occurs is an accepted practice in qualitative research. Moustakas (1994) outlined a three-phrase, seven-step process for analyzing the intense and descriptive data collected in a qualitative phenomenological study. The reason for the use of this procedure of data collection advocated by Creswell and Moustakas was considered in view of the nature this study. The approach adopted in this study followed van Kaam's seven-point analysis and Moustakas' (1994) four-step version respectively.

An assumption may be a starting point in theory that is necessary to build a theoretical explanation (Neuman, 2011). The reasons for requiring assumptions for a study may be critical to understanding every facet to anticipate participant responses and portray the knowledge and readiness of the researcher to undertake and complete a quality study. Assumptions are facts assumed right but not verified. An assumption therefore made of the expectation that the study participants would answer the questions honestly, reflects this necessity to factor a variety of different responses using critical judgment in the analysis of the data. The assumption was that the time allotted for the interview would be adequate to garner the information necessary to complete the study objectives. Another assumption is data would be free of recording and transcription errors. Reviewing and confirming the data by the participants confirms accuracy. The format of data collection facilitated the transferability of data into the NVivo software package to ensure textual analysis. The use of NVivo can enhance the accuracy of coding information into themes or patterns (QSR International, 2007).

Scope, Limitations and Delimitations

A purposive sample has the same characteristics that fit the study criteria (Fain, 2010). The site for this study was appropriate for conducting the research because of the selection of the participants. The integration of complicated instructions on medications into the patient's daily routine that it becomes a habit and leads to compliance presents difficulties for the patient.

We made each participant feel relaxed answering the interview questions truthfully and as they chose to respond to questions without rushing. Some participants did digress from the subject at times and had to refocus, for instance, the study volunteer who loves to bake had to frequently be brought back to the study conversation, and the interview guide served this purpose well.

Patient noncompliance in the elderly in the United States manifests in as a lack of adherence to health care advice. Some of the underlying reasons would include familial influences, for example if a family member had a reaction to aspirin; the patient may also develop the same symptoms, and so the patient refuses to take aspirin. Increased sensitivity or reactions to certain medications may also result in a failure to comply with medical directives that could be associated with a patient's socio-economic or educational background (Stewart, 2006; Troy, 2006; Warren et al., 2010; Kauffman, 2011). Poor adherence to medical treatment linked to poor quality of life, sub-optimal health resulting in frequent re-hospitalizations and higher health care costs (Graham & Lavicka, 2010; Laufs, Rettig-Ewen, & Böhm, 2011).

A Review of Literature

An extensive review of peer-reviewed literature helped in the uncovering of important themes related to the objectives of the research. The relevant title searches which produced the most results were medication noncompliance, medication noncompliance, chronic illness, aging and health care cost, medication errors, varying combinations of these words, online medical journals, World Wide Web, Government agencies. The identification and description of the main areas of the literature review served as a foundation from which to identify and build themes to describe the elderly perspective of medication adherence.

Title Searches, Articles, Research Documents, and Journals

The identification and description of critical areas of the literature review also served as a basis from which to identify and build themes to describe the elderly perspective of medication adherence, which provided adequate information on medication noncompliance. The literature review consisted of 107 peer-reviewed journals, articles, reports and research studies from the Center for Disease Control and Prevention (CDC) (2012), U.S. Census Bureau (USCB) (2009). National Council on Patient Information and Education (NCPIE), (2007), World Health Organization (WHO), Milwaukee County Department of Health and Human Services (2010). The literature review consisted of a particular search on medication noncompliance and related topics using ProQuest and EBSCOhost databases. Title searches that provided the most relevant information and included keywords such as elderly, medication adherence, chronic illness, medication non-adherence, medication costs and adherence, aging and health care costs, medication errors, and varying combinations of these words. The use of Internet search engines (for example World Wide Web and Google) for online journals and related websites affiliated with government agencies and nonprofit organizations yielded relevant perspectives on and resources for medication adherence.

Historical Overview

There are several studies of drugs and interventions to treat cognitive impairment (Barbhaiya et al., 2008). Rather than as one of the decisions, patients often continue with the evaluation of the experience of illness and the use of prescribed drugs after leaving the medical consultation. A patient's family members often may provide an accurate account to the health care practitioners regarding family member's medical history as the patient would not be forthcoming with the details in a truthful manner. Many patients have personal belief about an illness, medications and side effects, and often refusing to increase dosage medication, which can lead to noncompliance. Researchers have found the contributing reasons for noncompliance include confusion, lack of interest, time, inconvenience, and fear of medical treatment (Scheppers et al., 2006; Medalia & Revheim, 2011).

A cross-sectional study by Barat et al., (2001) of samples of randomly selected 348 persons, aged 75 years old, measured adherence with scores of agreements between the subjects' actual drug consumption and the general practitioners lists. The results from that study on medication noncompliance among the elderly indicated a discrepancy between the information gathered from the sample group and the general practitioners. At least 24% of participants did not follow the prescription regimen and took lower or less

frequent doses. Sixty percent of the subjects receiving hypnotics and knew the purpose of the medications and 20% were noncompliant. The results of the study findings indicated a connection between elderly patients living alone, the number of medications taken per day prescribed by a health care provider and noncompliance and early onset of dementia (Laufs et al., 2011). Barat et al., also found medication noncompliance among the elderly depended on the following: medications, as 58% of the subjects receiving hypnotics, and 36% using analgesics leading to noncompliance. Elderly participants often live alone, the number of prescriptions taken per day, and the onset of dementia appear inter-related (Laufs et al., 2011).

Discussion of Research Variables

In the African American community (Giger, Appel, & Davidhizar, 2008), pastors or ministers of churches often provide health-related educational material through health fairs, such as putting an announcement in the church newsletter or posting fliers in the joint area. Asking church members to donate items, donate personal time to register guests, baked goods, help with set-up, and clean-up is commonplace. As a coping mechanism, the African American church members use religious beliefs (Giger et al., 2008), to resist racial biases and discrimination. Churches in the African American community provide comfort, guidance, and inspiration (Warren, 1993; Giger et al., 2008).

In 1974, Stimson studied patients' beliefs about medication use. Patients hold personal viewpoint about medicines but quite different from the philosophy held by health care professionals. In a qualitative study, patients, and general practitioners were interviewed before, and after the medical consultation revealed that some misunderstandings exist between health care practitioner and patients concerning medication use (Britten et al., 2000). The lack of communication between patient and health care provider was often inaccurate as the health care provider would prescribe the medication that the patient would regard as unnecessary or beneficial (Ballard, 2004; Laufs et al., 2011).

In another interview-based study with patients referred to a rheumatology clinic, the findings suggested that patient beliefs have an effect on the decisions about the treatments. Patients were noncompliant in taking the medication according to the prescription guidelines, and the decision seemed made because of the adverse side effects of the drugs (Elliot et al., 2007). The patients make health care decisions based on experiences rather than asking the health care provider for instructions, and influences by family, friends, and the media (Donovan & Blake, 1992; Ballard, 2004; Bajcar, 2004; Laufs et al., 2011).

Many researchers have shown that specific drug attributes shape a person's perceptions of treatment. In particular, the color of a drug, its name, shape, and mode of delivery have been found to be important in influencing the way in which drugs are seen and used (Scheppers et al., 1970). From visual standpoints, the red tablets signify greater strength and potency, green tablets most efficient in the treatment of anxiety and yellow tablets, appear to be more suitable for treating depressive symptoms, connotes the importance of psychology in drug administration. The perception is that the drugs administered in injection forms are stronger than in pill form (Ballard, 2004; Bajcar, 2004; Laufs et al., 2011).

The responsibility for patient compliance rests equally on the efforts of health care providers, in their providing

appropriate guidance, support, and education. Patients can express personal health beliefs to the health care provider, and health care providers can convey their medically informed health beliefs to the patient (Ballard, 2004). The health care providers define concordance as the medical practitioner and the patient working in collaboration. Patients often leave the consultation with a physician, with an agreed decision about the prescribed and treatment and the imperatives thereof (Ballard, 2004). It is a reflection of a much wider debate among sociologists, and patients hold individual beliefs about health and illness, which shape their decisions about treatment (Ballard, 2004). Within this context the concept of compliance, or noncompliance, thus it is in which patients viewed as passively following or disobeying medical instruction is problematic (Ballard, 2004). The extent to which patients are equal partners in the health care provider-patient relationship, however, this needs further consideration (Ballard, 2004; Laufs et al., 2011).

Researchers may need to focus on determining whether patients wish to participate in discussion about treatment and prescription medicines. Also, another consideration on whether health care providers are prepared to relinquish some of their autonomy, surrounding the prescribing of medicines may require additional thought (Ballard, 2004). Unless both the practitioner and the patient can move toward an equal partnership, the concept of the concordance will have little more value than being a politically correct term for compliance (Ballard, 2004).

In the literature review, an examination of several theories and models in the search for solutions to the challenges of noncompliance faced by the elderly African American population was included. A better understanding of the problems as the locus of control, health beliefs, spirituality, and other mitigating circumstances that the elderly participants face regarding the lack of awareness of their health conditions inadequate health insurance coverage. The lower economic situation, cognitive deterioration, multiple-drug regimen, and comorbidities are just a few of the burdens that face the elderly when deciding compliance. Undertaking the literature review also provided the opportunity to conduct an in-depth theoretical review, to select an appropriate theory in serving as the foundation for understanding the phenomenon of why some elderly African American's comply, and others do not. The extensive review of the literature and the accompanying data confirmed the need for further research to gain additional knowledge into the internal and external factors that affect the decision-making of the elderly African American study participants.

Methodology

An exploration of how individuals view society and the subjective experiences of reality align with understanding the lived experiences and the discernment of the elderly African Americans. The information gathered may support healthcare providers in becoming knowledgeable, aware, experienced in attending to the needs of the geriatric population, and contribute to the development of programs. The discussion under methodology also includes a discussion of the geographical location of the study, and details on the rationale and choice of the selected research methodology, interview guide, and other aspects of the data collection and analysis. A discussion of external and internal validity concludes the discussion of the research method and design.

Research Method and Design

Ethnography and a case study design were inappropriate for this study. Ethnography is a research study procedure used to describe, analyze and interpret the activities of the group of people (Creswell, 2005; Leedy & Ormrod, 2010; Tozer et al., 2014; Moustakas, 1994). Ethnographers generate understandings of culture through representation or an "insider's point of view" (Hoey, 2014). The significance of the research is in allowing meanings and critical categories to emerge and from the ethnographic meeting rather than imposing ideas from existing models (Hoey, 2014). The ethnographic design was not deemed useful to capture the lived experiences of the participants, as the researcher, although immersed in activities, becomes an observer rather than interacting with the participants of the study.

Hermeneutic phenomenology involves an intense focus on the subjective experience of groups and individuals. The endeavor is to experience the lived experiences through the life stories of the participants (Kafle, 2011). A transcendental phenomenological design, on the other hand, was not appropriate, as this design entails gaining an understanding of a phenomenon's general characteristics rather than the individual's experiences related to the process (Kafle, 2011).

A researcher using a grounded theory design generally wants to study a process, or explain a process. Among the most common qualitative designs is grounded theory: that produces phenomenon grounded (Polit & Beck, 2010). The idea in such a design, will be to generate new theory; grounded theory would need a large group of individuals (Creswell, Hansen, Plan-Clark, & Morales, 2007; Arvidson, 2015). Grounded theory was considered inappropriate for this study because the intent was to understand the lived experiences of the elderly African Americans as it pertained to medication compliance (Leedy & Ormrod, 2010; Moustakas, 1994; Smith et al., 2009; Tozer et al., 2014). The focus of the research was not to develop a theory about noncompliance, rather to explore it from the first-person accounts of participants.

A case study is an in-depth exploration of an individual, event, activity, or process used to learn about a situation where little is known, or that is poorly understood (Leedy & Ormrod, 2010; Tozer et al., 2014). A case study was also inappropriate for this study because the focus of the inquiry was to explore the elderly African American's perspectives and lived experiences to understand better the phenomenon, not to develop an in-depth understanding of a case. A qualitative phenomenological approach was found necessary, a determination made after an extensive review of different research design and options under the qualitative methods umbrella, and found suitable to explore and understand the phenomenon and gain first-hand information from the participants.

The theory of phenomenology espouses a focus on exploring the beliefs, perceptions, and knowledge of individual members (Kisely & Kendall, 2011). Investigating the philosophy of phenomenology can increase research quality (Converse, 2012). Creating ways to produce results is reflective of good efforts in striving to gain a deeper understanding of perceptions and participant lived experiences. The anticipation of promoting a culture of learning and discovery of new ideas is central to enhancing the reliability of the study, and was followed in this study as well.

Qualitative research is learning about the experiences from the perspectives of the participants. The goal in this study was to elicit the responses of the participants based on personal experiences. To facilitate participant participants to freely express thoughts, the following represented the research setting (a) the researcher must listen to the views of participants in the study; (b) the researcher needs to ask open-ended, general questions and collect data where people live and work. (c) Research results should contribute in some way to bringing about change and make individuals' lives better.

Empirical Inquiry

According to Giorgi, (1985, 1987, and 2003), empirical phenomenological model has two levels: In level I, the original data is comprised of descriptions obtained through open-ended questions and dialogue. In level II, the researcher describes the interpretation and analysis of the participant's lived experiences. The method of analysis is as follows:

1. The researcher gains an idea of the big picture by reading the whole statement.
2. Focusing on the different prospects' and possibilities of the phenomena under study: The elimination and clarification of redundancies and elaboration and correlating to make a sense of the whole.
3. Transformation: The next step is to translate the information into scientific psychological language of the participant's expressions.
4. Synthesizing of the experience of each participant's experience.
5. Synthesizing the entire experience in concise form: Captures and describes the experience of the participants (Giorgi, 1985, 1997; Giorgi & Giorgi, 2003).

Research Questions

The overarching research question for the study was RQ: What knowledge of the lived experiences of elderly African American patients could foster improved physician strategies to enhance medication compliance?

Members of the congregation were requested at the end of church services asking for participants for the study and that there was a letter of introduction they could obtain from the Pastor with the inform contact number of the researchers. The members of the congregation received assurance that all information and inquiries were confidential, and no one in the congregation would know who would be participating in the study. The members of the church, fulfilling the participation eligibility criteria for the study, scheduled face-to-face interviews at personally convenient times.

Oliver (2006) noted that a minimum of 20 participants is adequate in qualitative studies to constitute an appropriate sample. According to Giorgi, (2003), and Moustakas (1994), in-depth interviews can provide valuable data to capture the lived experiences of selected and eligible study participants. The knowledge of the individual and the insights gained from talking to them offered a glimpse into the decision-making process of the elderly concerning medication compliance. The participants in the study included low-income, retired, and living on fixed budgets, or Badgercare, (funding from the state).

Ethical Considerations

The data collected from the interviews was sorted, and coded based on a two-digit tracking code assigned to participants and logged in a spreadsheet. Monitoring systems consisted of a two-character code, 01 through 20, which represented the order in which the members agreed to take voluntarily part in the study. The representation allowed the

identification of each participant but also provided complete confidentiality to each.

In phenomenology, the focus is on shared meaning and consciousness, (Moustakas, 1994). The coding of data reflected the basis for descriptions and definitions (Merriam, 2009). The analysis consisted of an inductive process of sorting data into similar categories and identifying patterns and relationships among the groups (McMillan & Schumacher, 2010). The systematic process commenced with accurate data and ended with groups and patterns. The goal of data analysis was to find answers and share descriptive feelings and detailed thoughts concerning the research questions in the dissertation. The analysis of the data involved identifying recurring patterns that described the data (Merriam, 2009). The process of examining, categorizing, tabulating, and recombining data into patterns or themes took place during the analysis phase of data collection (Roberts, Priest, & Traynor, 2006). Data collected consisted of a single descriptive word or a combination of words or sentences. The aim of data collection and analysis was to obtain meaningful information from the participants, which applied to form categories of themes, patterns, or findings from the research questions (Kisley & Kendall, 2011).

Permission for recruitment, and reference to the institution was obtained before data collection. The church granted authorization to use the premises for the interviews to take place in a quiet conference room convenient for the participant and appropriate for audio recording, and interviews did not take more than an hour per session. Maintaining confidentiality of private details and information adhered to throughout the research project. Participants became aware of the importance of confidentiality and privacy before the collection of data, and informed of the nature and purpose of the study before the selection process. An important study requirement included the distribution of informed consent forms to only members, who agreed to the face-to-face interview to answer questions about the study. The notification passed out, indicated that the personal information provided is confidential before the signing of the informed consent form. The study data and information collected on tape recordings are stored securely using a lockbox, at the church's interviewing room, to ensure participants responses and personal information remain confidential and safe. The research planning included seeking permission to use the premises and the assistance of the pastor for the recruitment of study participants. The site for conducting the study was within walking or driving distance, in efforts to guarantee the comfort of the participants. Informing respondents', the goal of the interview was to participate in a research project, which aimed to develop an understanding of nature was important to communicate the initial phase of data collection. Promoting a sense of respect ensured a nonjudgmental and nonthreatening environment conducive for a smooth interview process. Depicting the essence of the experience in community situations provided individual learners with a sense of cultural competence and ensured a higher level of knowledge and comfort during experiential learning (Converse, 2012).

Statement of Confidentiality

Maintaining the confidentiality was by securing research data to avoid the possibility of exposing participants' information. As a safeguard, the promise of secrecy was upheld (Kaiser, 2009). The interviewees were

chronologically numbered in the order in which the interviews took place to ensure meeting control standards and protocols. Each transcription, form, volunteer, interview had an assigned identification number 01-20. Only the researchers knew the identity of the participants. Applying specific measures helped to ensure confidentiality. The interviewer's ability to protect their identity and keep the anonymity allowed the participants to remain confident in the researchers. The interviews included conversational dialogue and open-ended questions relevant to the guiding research questions. Self-reports in the data collection were emphasized to value the contribution of new knowledge on the topic and an illumination of meaning to the questions. At the end of the interview process and stage of data collection, participants had an opportunity to review and confirm or modify research data to correspond to the perception of lived experiences (Moustakas, 1994).

The confidentiality provisions enacted in this study also included sharing of results with the healthcare provider in an emergency and with the member's permission; otherwise, the identity of the study volunteers will remain confidential, and not disclosed to any outside party, and even with the publication of the results of this research study. A locked filing cabinet to store the data such as the NVivo10 disc, the transcription tapes, and consent forms, the typed reports, and the key to the cabinet are in the sole custody of the researchers. The data will be shredded, and incinerated after three years from the completion of the study. Any participant in the study showing signs of discomfort or confusion that was age-related could have requested stoppage of the interview, permanent termination without any negative implication; however, this was not an issue in this study.

The ability to conduct a phenomenological study is a strength gained through personal and professional experience as a registered nurse (RN), 18 years and certified nursing instructor, eight years, with a fellow researcher steeped in academia. The nature of professional occupation involves working with patients suffering from dementia, Alzheimer's disease, and various other afflictions. Graduate qualifications of the researcher with a Master's in Nursing (MSN) and a Ph.D. in management of the other researcher, ensured appropriate scientific and research skills to successfully complete this phenomenological study. Graduate and doctoral qualifications therefore served in good stead to undertake to understand clinical diagnosis treatment, follow-up, and other clinical protocol assessments, for which techniques used are like phenomenological principles, as required in an in-depth understanding of patients.

Instrumentation

The nature of knowledge and the construction of information may reflect the researcher (Merriam, 2009). Through nonverbal and verbal communication as a researcher, expansion played a role in processing information, clarifying information, and summarizing material immediately from the participants (Merriam, 2009). A key component of obtaining a rich, detailed set is to focus on the way in which members make sense of their life through meaningful interpretations of experience. The primary focus is to understand the phenomena from the participants' perspective and the researcher's viewpoint. Merriam (2009) referred to the volunteers' perspective as the emic or insider's perspective.

A pilot test preceded the main research study and involved four healthcare professionals who reviewed the

interview guide and the interview questions. The qualitative research pilot test experts read the research questions for clarity and ease of understanding. Upon review, the professionals found the questions to be clear and easily understood.

Interview Guide

The following list of questions is a guideline the participants asked during the interviewing process:

How would you describe your interaction with your physician and medical staff?

What are some of the important thoughts on the way you cope with your medication?

What are your experiences when you miss your medication, as opposed to when you do not?

How would you describe the support of your near and dear one's in daily life with your existing condition?

In the framing of the research questions, the aim included achieving congruence with a phenomenological design and gain insight into the lived experiences of elderly African American participants in their personal efforts at complying with prescribed pharmacological treatment.

Epoché Process

Bass, (2009) discussed the importance of considering the validity and reliability of the research instrument. Salkind (2008) stated that reliability and validity are the first line of defense to protect the integrity of investigation and guard against incorrect conclusions. In the process of describing phenomenological research, steps have been suggested for the conduct of phenomenological inquiry for accurate validity and reliability (Leedy & Ormrod, 2006), and such measures instituted served to ensure meet validity and reliability standards. The steps included bracketing, sensing, analyzing, and describing (Morse & Field, 2007). Using epoché or bracketing, keeping in mind the importance of internal and external validity as it pertained to valid and meaningful conclusions that have applicability and relevance beyond the specific research at hand. Creswell (2008) and Moustakas (1994, p.56) suggested that in the epoché or bracketing process, the researcher refrains from taking a position instead ascribes equal importance to every quality.

Field Testing Information and Results.

The purpose of field-testing interview questions was to ensure the validity of the data collection instrument (Fain, 2013). Determining whether the interview script would provide an adequate means to answer the research questions was a critical point in data collection. Identifying the readability level of the interview questions and expected probes was necessary to ensure clarity and provide respondents with a clear understanding of each issue. Appropriate considerations included determining if each issue written at a grade level suitable for the respondents. Testing of the data collection instruments (see Table 2) took place using four research specialists from a large medical center in Wisconsin.

Interviewing

Face-to-face interviews used to ensure individual participants have an opportunity to reflect on the lived experience of the elderly African Americans with medication compliance. Clarification and probing for additional in-depth data obtained during the interview with immediate responses to questions from the researcher (Christensen et al., 2010; Merriam, 2009).

Table 2

Field Test	Respondent Credentials, Experience, and Relevant Training	Suggestions and Comments
Expert 1.	Senior research scientist at Aurora, and the clinical assistant professor at the University of Wisconsin. Working with Boston University on a Medical School and Public Health. Working with Boston University on a pharmacological medication adherence system for post-hospitalized patients for monitoring compliance. (Aurora Medical Center, 2015)	You need to look at the big picture- Why are they noncompliant? Can they afford their medications? Do they have side effects?
Expert 2	Senior Administrative Assistant. Provides administrative support to the directors of investigator- Initiated Sponsored Research and Clinical Trials (Aurora Medical Center, 2015)	1. Cluster all medication questions together. 2. Put all emotional emotional/reactionary questions together.
Expert 3 Expert 4	Fellow and senior research associate at MCW. Physician (Surgeon-urologist). Specialist, Qualitative Researcher, experience with Phenomenology (Aurora Medical Center, 2015) Bachelor of Arts in Psychology, certified through the Association of Clinical Research Professionals (ACRP) since 2010 (Aurora Medical Center, 2015)	1. Ask multiple choice, and fill in the blank questions if you need to help them feel comfortable. 1. Keep medication questions together. 2. Keep mental questions together

The use of open-ended questions facilitates participants to share experiences by reflecting on detail and offering descriptive details regarding a phenomenon (Hart, 2008). Interviews are ideal for participants to share insightful and meaningful experiences. Using follow-up questions provides an opportunity for the participant to reflect on additional ideas and experiences allowing the researcher to collect more data relevant to the original question.

Probing questions aids a researcher to adjust questions during the interview process. Asking for more detail or clarification may be examples of when probing for additional information may be warranted. Silence, sounds, a single word, multiple words, or a complete sentence may be examples of reasons to probe for further details. Who, what, when, and where questions are typical questions are examples used by researchers to probe (Merriam, 2009). Possible probing questions will often enhance meaning and provide rich detail during the interview (Fain, 2013). Interviewing is necessary for situations where information from past events is impossible to replicate (Merriam, 2009).

The interviews progressed until data saturation occurred, which represented the efforts to instill the appropriate research rigor and denoted the point where no new information was forthcoming in interviews of the same

participant, and evident after interviewing 15 participants. Discernible data saturation in this study upon interviewing 20 participants led to the conclusion of data collection. The sample size was adequate to gather responses to the to gain insight into the factors that facilitated, or hindered patients keeping to personal physician's questions of prescribed medication compliance using the open-ended questions and served medical treatment plan. We met with each of the participants to request review the written transcript and confirm accuracy. Participants clarified and endorsed the interview transcripts for accuracy and received a copy.

The research questions aimed at obtaining insights into patient's views and lived experiences on the spectrum or reasons and challenges attributed to noncompliance, ranging from willful and inadvertent compliance failure, to deliberate noncompliance. The interview questions open-ended design facilitates participants expressing and sharing personal lived experiences of medication compliance. Using an Interview Guide and the interview questions therein, enhanced the ability to structure the interview process. The interview question remained unchanged for all participants to ensure consistency, and follow up questions varied to elicit responses in keeping with personal situations. The aim was to gain insight on the participant perceptions as it related to challenges in maintaining compliance with a personal prescription medication regimen.

Organizing the numerous answers that resulted from the triangulation process, reorganizing the many themes into smaller related groups, helped to increase data manageability and significance, and this process aided in the uncovering of substantive meaning in the pathway to meeting the study objectives. The organizing of the themes helped in narrowing down the number to the following five categories: challenges participants to achieve compliance; ways participants avoid noncompliance issues; managing successful compliance to health care treatment strategies, volunteers use to overcome compliance challenges; and ways that influence members to comply.

The transcription of every participant interview represented the data collection of the lived experiences of the elderly African American participant responses and analysis. The five key themes emerged from the participant's experiences. The interviews were audio-recorded and transcribed. Participants then upon receiving a phone call to confirm a day and time for transcript review, came in to do so, congruent with the process of member checking. Transcript reviews took place either at the church or in the volunteer's home keeping the choice and convenience to the participant uppermost in this study.

Data Management

The transcription and data analysis was the responsibility of the researcher. The process of participant checking included confirmation of the transcribed data. The reproduced data shown to the volunteers for review and revisions made if necessary to enhance the accuracy of the data. Participants approved the transcripts before data analysis to assure the accuracy of the transcript. After receiving approval from the participants, the use of NVivo software used to code the transcribed data into themes. As outlined, data collection information sorted, and coded based on a two-digit tracking code assigned to participants and logged in a spreadsheet. Tracking code consisted of a two-character code, 01 through 20, which represented the order in which the participants agreed to take voluntarily part in the

study. The representation allowed the identification of each participant but also provided complete confidentiality to each. In phenomenology, the focus is on shared meaning and consciousness, (Moustakas, 1994). The coding of data reflected the basis for descriptions and meanings (Merriam, 2009). The analysis consisted of an inductive process of sorting data into similar categories and identifying patterns and relationships among the categories (McMillan & Schumacher, 2010). The systematic process commenced with accurate data and end with categories and patterns.

The qualitative method and the phenomenological design chosen for this research project were appropriate because it involved a naturalistic interpretative approach to the subject matter (Sandelowski, 2010). The study entailed audio recording of face-to-face interviews, to facilitate gaining insight into the lived experiences of the participants on personal challenges to comply with medical related pharmacological treatments and supervision. The details herein also included a discussion on the recruitment of the participant volunteers, representing the purposive sample, the research method details, and the description of the data collection, and research instruments. The description of the capabilities of the NVivo qualitative data analytical software program, the geographical location, and the process for the recording of the study in a large urban city in Wisconsin completed the details. According to Giorgi, (2003) and Moustakas (1994), in-depth interviews pertain to capturing the lived experiences of study participants and perceptions, and how these individuals make decisions.

The study involved as stated, the invocation of a qualitative method and a phenomenological design to understand the lived experience of the elderly African American compliance in daily life with the medication prescribed by a personal physician. The data analysis included the use of NVivo qualitative data analytical software. The research in this qualitative phenomenological study included the audio recording of face-to-face interviews, to gain insight into the lived experiences of the participants in the study. Next, the details related to participant demographics, data collection, and the presentation and analysis of the data as well as the presentation of the study findings and pertinent discussions will follow.

Study Findings and Results

A discussion of the findings and analysis of the data using an empirical approach is presented here with. This study findings and results consist of four main sections, each contributing toward the essence of the studied phenomenon. The first section consists of the demographics, which consist of the defined attributes of each participant. The second section comprises the collection data procedures, development of the interview script, field-testing of the interview questions, a discussion of the processing and analysis of the research data, and the use of the NVivo software to store, organize code, and analyze the data. The third section includes a presentation of the data results. Themes, sub-themes, and the significance of the responses will allude to the number of participant responses producing thick, rich, descriptive results. The fourth section consists of the narrative depictions from the reflections and verbatim transcriptions of language expressed through the interview process. This component ends with a summary and conclusion linking the research findings to the purpose.

Recruitment Process

Members of the congregation were addressed at the end of a church services asking for participants for the study, and a letter of introduction explaining the intent and purpose of the study they could obtain from the pastor with the contact number of the researcher. The pastor was informing the members of the congregation that all information and inquiries were confidential, and no one in the congregation would know who would be participating in the study. All interested participants called and scheduled face-to-face interviews, which were at the convenience of the volunteer participants. The church granted permission to use the premises for the interviews to take place in a quiet conference room convenient for the participant and appropriate for audio recording, and the interviews did not take more than an hour.

The qualitative phenomenological study was an efficient method for discovering the significance of a multifaceted experience. In addition, it is the method used for recruiting the participants for this study using specific screening and eligibility criteria in drawing a purposive sample from the congregation in Wisconsin. Representing the overall population and was lived by the elderly implicated in the study. The qualitative data and information gathering entailed the interviewing of 20 elderly African American individuals in Wisconsin currently receiving treatment for various medical conditions.

Data Collection Process

The interview process is the method of choice for collecting data in phenomenological research (Moustakas, 1994). Merriam (2009) indicated obtaining quality data is dependent upon the types of research questions and the way in which the questions asked. Open-ended questions facilitate probing by the researcher for additional information and asking for clarification. Thinking inductively also helps the research to move from specific to abstract categories and concepts (Merriam, 2009). Interview questions used to promote descriptive rich data significant to the topic under investigation. The interviews progressed until data saturation occurred, which represented the efforts to instill the research appropriate rigor and represented the point where no new information was forthcoming. Completing the interview transcription took place on the same day to describe the feelings of the participants and to obtain the most accurate and honest answers. The data analysis included the use of the NVivo 10 qualitative data analytical software program for coding and cataloging. A copy of the transcription of the interview given for review, clarification, additions and omissions, and sign copy to returned to the researcher.

The purpose of this qualitative, phenomenological study using a face-to-face interview method was to gain insight into the lived experiences of elderly African Americans regarding noncompliance with their physician's medication regimen. Backup copies made and stored to safeguard against fire, damage, theft, and ensure confidentiality with password protection known only to the researcher. Moustakas (1994) outlined a three-phase, seven-step process for deriving scientific evidence in phenomenological investigations. The reason for the use of this approach of data collection was based on the type of study. Phenomenological studies require gathering the lived-experience directly from the participants.

The using and asking of the interview questions followed standard research protocol and guidelines. The first few minutes before initiating the questions, time spent explaining the face-to-face interview process.

The next few minutes provided for the review the Informed Consent Form, for answering any questions or concerns, and for the participant to sign and date the form. Each participant received a copy of the informed consent form. Study participants received a phone call to confirm the day and time for transcript review. Transcript reviews took place either at the church or in the volunteer's home because of convenience to the participant. For tracking purposes, each member dated and signed the last page of the interview transcript to confirm accuracy and review, and each given a copy of the transcript.

Data Analysis

The data analysis in the study involved carefully verifying the data by listening to the recordings and comparing the recordings to the transcripts. Each interview session was coded by using, the audio recorders alphanumeric file naming coding helped to ensure confidentiality and anonymity in the recordings. Study identifications assigned to each participant file of the transcriptions represented a measure to make certain anonymity was not compromised in any way.

We met with each of the participants to review the written transcript, to confirm accuracy, for clarification of the interview transcripts, by requesting each volunteer to read, sign and then receive a copy. Data coding and categorization followed the data collection phase. Data reduction involved classifying and assigning a code to categorize the data into themes and patterns. Storing, organizing, and determining patterns took place with the aid of NVivo 10 qualitative data analytical software immediately after the participant confirmed the accuracy of the respective interview for accuracy. Using a process of constant comparison, repeated trends and themes emerged as patterns in the data were illuminated. Data preparation and analysis procedure followed the steps suggested by Moustakas (1994, pp. 120–121) in the modified Van Kaam Method. The features and capabilities of the NVivo10 software facilitated data analysis (Bass & Avolio, 2012). The process and steps to analyze data included (a) importation of interview transcripts (copy) from rich text into the NVivo 10 database; (b) collection of answers to the questions interviews data. (c) Drawing a link with other data, such as literature reviews; (d) coding the responses; and (e) shaping data in sets. (f) Examining relationship between data, ideas, and information stored, (g) asking questions about the data, found patterns, and (h) generating a report.

The research questions aimed at obtaining insights into patient's views and lived experiences on the spectrum or reasons and challenges, ranging from willful to inadvertent compliance, to noncompliance. The interview questions designed with focus and open-ended facilitate dialog and freedom of expression for each participant to share personal lived experiences in the efforts to achieve and maintain compliance. Using an Interview Guide with interview questions enhanced the ability to structure the interview process, and the underlying question remained consistent. This preparedness helped to gain insight, detail and personal insight into the participant's perception as it related to challenges and reasons for maintaining compliance with a personal medication regimen, or failing to and related issues in following treatment directives of a physician.

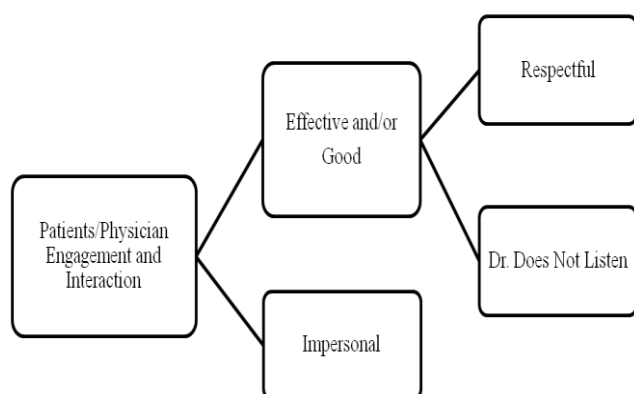
The literature reviewed, offered some insight into the main facets identified as pertinent to critical thinking and competence in undertaking this study. The two research questions and ten interview-subset questions guided the

study. The transcription of the participant interviews represented the data collection into the lived experiences of the elderly African American participant's responses and analysis. From the analysis of the interview transcripts, 14 themes emerged, reflecting important commonalities in participant experiences, which when listed in order of importance, provided some details on the importance of the challenges and the trysts in abilities and circumstances leading to compliance and failing to appreciably to so, from the replies to interview questions. The interviews were audio-recorded and transcribed to facilitate scrutiny and derivation of themes common to most, which also help to uncover the most important aspects of these discussions and lived experiences.

Theme 1. Patient/Physician Engagement and Interaction

The communication of participants with a personal physician and medical staff are reflected in the interview responses and the analysis of the transcribed qualitative data. Most participants (63.9%) expressed a favorable disposition towards health care providers, as Effective and or good, while other members felt physician and patient engagement was impersonal (18.1%), Respectful (13.6%) while some (4.5%) participants stated that the doctor does not listen to complaints (4.5%). The question, which elicited these responses: "How would you describe your interaction with your physician and medical staff?"

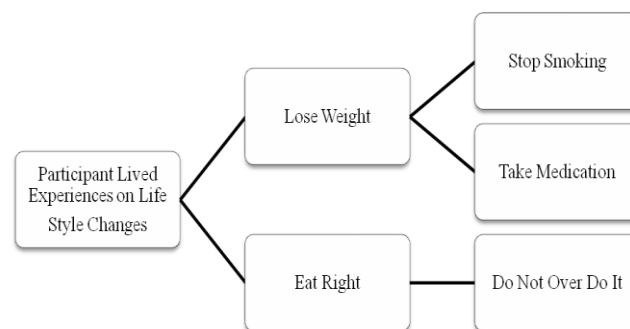
For the most part, participants viewed the health care provider as efficient and or good; "I go to the Veteran's hospital, and they are fantastic over there." (Effective and or good) As denoted by 63.6% of responses to this question. However, one-third of the patients interviewed also felt that their doctor was either impersonal (18.1%), or failed to listen: "I have a new primary doctor, he's impersonal, but he knows what he's doing," or patients felt that their health care provider does not listen to them at all." The doctor doesn't even look at it. He never listens to me when I try to tell him anything."



Theme 2: Participant Lived Experiences on Life Style Change

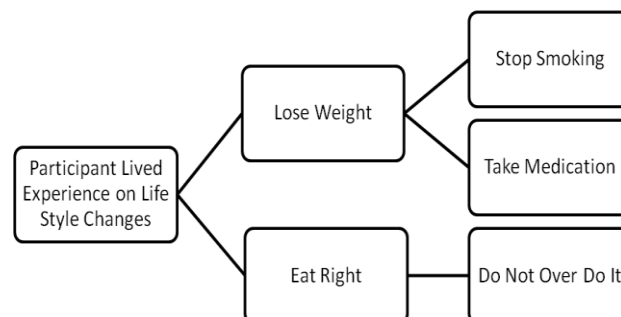
Participants' responses to the initial reaction to diagnosis ranged from Surprised (33.3%), Resistance and or indifference (25.0%), Angry (25.0%), Depressed (8.3%), and Scared (8.3%).

"My first reaction was surprised. I thought that this could never happen to me." "I was afraid of life. Oh I didn't want to hurt myself or anything like that it just scared me." "I have diabetes, and I'm just glad I don't have to take the shots." "I was pissed, combative, why do I have to take the meds?"



Theme 3: Reaction to Initial Diagnosis and Life Style Change Imperatives

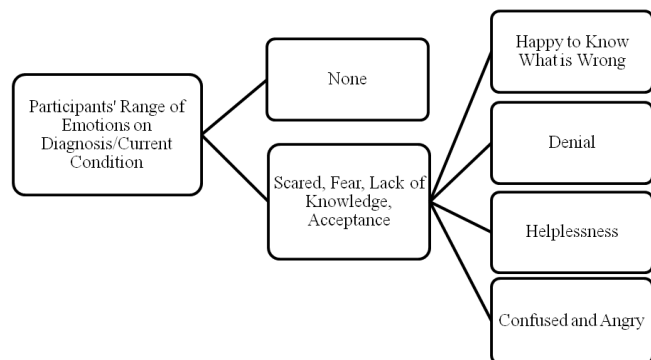
The portrayal of the reaction to the initial diagnosis was an emotional story as many expressed surprise, anger, and resistance conveys the range of emotions. One patient stated, "My first reaction is scared to death." On the other hand, "My reaction is frustration, and they still don't have the answers." The elements of surprise (33.3%), and scared (8.3%), that interpretation of indifference and or resistance triggered because of financial difficulties. A patient stated that they were so scared by the diagnosis and maintained a strict regimen for only six months; "Then I let things slide, you know the holidays were coming, and I need to bake, and well money was getting tight, so I didn't always get my drugs filled."



Theme 4: Participants' Range of Emotions

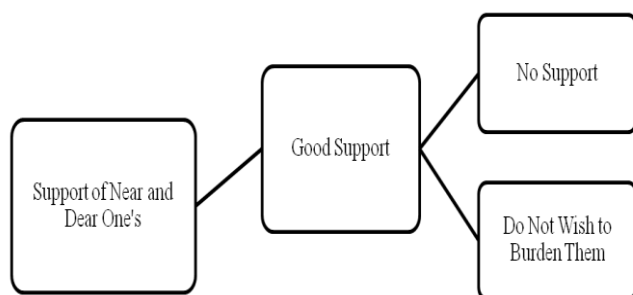
Participants expressed a range of emotions regarding the personal trauma and feelings when initially diagnosed with the illness. Responses ranged from none (23.8%), Scared, fear, lack of knowledge, acceptance (19.0%), Happy to know what is wrong (9.5%), Denial (9.5%), Helpless (4.8%), and Confused and Angry (3.3%). Participant #3, expressed self-blame for exacerbation of the condition: "I felt upset with myself because I did this to myself. I knew I didn't need to feel this way if I had taken my medication. So, I should make sure that I take my medications."

Emotions ranged from confused and angry (3.3%) to No feelings at all (23.8%). One patient stated, "I was diagnosed with chronic obstructive pulmonary disease, I was scared I didn't know what COPD was. I went from fear and confusion to acceptance to regaining control." Patients experienced happiness at times when first receiving the initial diagnosis out of relief to know that they are finally getting answers to their ailments. One patient stated, "Emotions, I cried inside because I was happy to know what was wrong with me." 12: 9.5%. Happy to what is wrong. The interviews saw a range of emotions expressed by participants upon initial diagnosis and in some instances, this 'news' lead to an exacerbation of the current condition.



Theme 5: Support of Near and Dear One's

Participant responses relating to family support indicated that family dynamics plays a crucial role in health wellness, and it is dependent on the patient as to whether they want the family and significant others involved in that situation. Some of it are by the patient's choice, while other times, it is by the family choice for whatever reason. The views reflected the overwhelmingly the value of Good support (81.0%), No support (14.3%), do not wish to burden them (4.8%). One patient stated, "My family and friends support me, and remind to take my medication, to check my blood sugar and to eat right. They get upset with me when I don't eat right, but I like my sweet tea and red velvet cake, so I cheat, but not as often as I used too."



Conclusions and Recommendations

The lived experiences of each participant were the focus of the emergent themes. There are 5 emergent themes and 68 invariant constituents because of the participants' responses to the interview questions. The questions allowed the participants to engage in an open dialogue about their lived experiences, and the opportunity to recall the specific event. Researchers have indicated that providing quality patient care begins with clear and appropriate communication, and collaboration is impossible without communication (Arford, 2005; Weeks 2004). Patients' have reported that on an average doctor only spend three minutes discussing the new medication especially if the patient is newly diagnosed with the illness. This counseling session is not enough education especially when patients are on multiple medications, and lack the knowledge regarding personal illness.

Theme 1: Reaction to Initial Diagnosis and Life Style Change Imperatives

The positive implications of compliance included favorable responses summarized from the interview excerpts: Patients seem to "feel good" when they do not miss their medication (55.6%) Feel good: "When I don't miss my diabetes medicine, I am less temperamental." Another stated, "If I take my medication and eat right, I feel good" (55.6%) and nothing happens such as no adverse conditions when "I take my medications and do not miss any" (22.2%).

Theme 2: Participants' Range of Emotions

The responses and lived experiences of participants regarding the initial diagnosis of their existing and current medical condition provide further knowledge on medication compliance. Participant's responses to personal lived experiences regarding initial diagnosis ranged from Upset/Helpless (63.6%), Scared (18.1%), Angry (13.6%), and Relieved (4.5%). One respondent expressed anxiety for being on the waiting list for a transplant and a biopsy: "the waiting time for the tests is unbearable. I'm Scared." The inference drawn is that there is the opportunity for more support by the physician and staff to forge stronger bonds after the initial diagnosis, which may bode well for greater medication compliance in the subsequent treatment, and stronger bonds of patient and physician collaboration.

Theme 3: Participants Perspectives on What Can Be Better?

For the most part, participants viewed the health care provider as effective and or good; "I go to the Veteran's hospital, and they are fantastic over there." (Effective and or good) as denoted by 63.6%. However, one-third of the patients interviewed also felt that their doctor was either impersonal (18.1%), of failed to listen. "I have a new primary doctor, he's impersonal, but he knows what he's doing," or patients felt that their health care provider does not listen to them at all." The doctor doesn't even look at it. He never listens to me when I try to tell him anything."

The largely positive experience also bore some concerns as seen in the analysis, with the impersonal but efficient, and the propensity not to lessen suggesting opportunities for physicians to ameliorate relationship and listening skills.

Theme 4: What Can Be Better Concerning Your Treatment?

The University of Illinois–Chicago (UIC) School of Public Health develops programs and participates in national and international research efforts that's to keep disease prevention the focus and management and not the disease process. The impetus for HELP came from the school's participation in the Department of Health and Human Services Office of Minority Health Patient-Centered Care Collaboration (PCCC) initiative, which explored use of comparative effectiveness research to reduce health disparities. PCCC disseminated evidence-based practices that providers can use with racial and ethnic minority patients with diabetes, hypertension, or obesity (U.S. Department of Health and Human Services Office of Minority Health, 2014).

The program increased disease-related knowledge and self-confidence, which in turn led to better self-management behaviors and short-term improvements in blood glucose and systolic blood pressure control and quality of life. Increased knowledge and self-confidence: In a study of 38 African-American participants, knowledge of diabetes, overweight/obesity, and hypertension significantly increased between baseline and the end of the program, with the percentage of correct answers on a knowledge questionnaire increasing by four, three, and 11 percentage points, respectively. The ratings of self-confidence, also, increased, from 2.40 to 2.71, on a scale of one to three, with three being "very confident" (U.S. Department of Health and Human Services Office of Minority Health, 2014).

Patients can find it difficult to adjust to lifestyle changes that are required in or to meet with compliance with doctor's orders. Even though patients are fully aware of the

consequences of noncompliance, there are challenges: "I don't take the right amount of insulin, I could go into a coma, lose a leg, or go blind, only 9.7% meet compliance standard (Take medications). The personal participant views on the imperatives for lifestyle changes where the challenges to lose weight and maintain a stipulated diet present challenges. Participants' responses to the initial reaction to diagnosis ranged from Surprised (33.3%), Resistance and or indifference (25.0%), Angry (25.0%), Depressed (8.3%), and Scared (8.3%).

Theme 5: Support of Near and Dear One's

There is a connection between prior poor experience with a treatment regimen and psychological factors. Patients may be successful with compliance regarding medication adherence with the assistance, companionship, and emotional support for family members (Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006; Delamater, 2006; Medalia & Revheim, 2011). Support systems appear to be imperative and a dominant factor when addressing the issue of patient compliance regarding medical treatment plans. One patient stated, "My family and friends support me, and remind to take my medication, to check my blood sugar and too eat right. They get upset with me when I don't eat right, but I like my sweet tea and red velvet cake, so I cheat, but not as often as I used too."

The inference from the above analysis may indicate counseling opportunities by physician staff family and individuals who help the patient, to improve the therapeutic outcomes in contribution to the quality of life and better compliance. This section represents the culmination of the study and includes a discussion, interpretation of the analysis, and conclusions, and recommendations resulting from the data gathered. The other points of discussion include recommendations for collaboration and teamwork among health care professionals, the scope of the patient-centric legislation, and the training potential and possibilities in medical schools in the realm of elderly patient care.

Gaining an understanding of the experiences and insight into the lived experiences of the elderly African Americans regarding medication compliance has led to exploring how individuals perceive, conceptualize, and understand an everyday experience, and how it relates to medication compliance. The findings of the study may help to contribute to improving health care leaders' understanding of interdisciplinary communication and collaboration among nurses, health care practitioners, and unlicensed assistant personal, and facilitate patient safety. The study findings may also serve to provide valuable knowledge to other researchers, professionals, and the public. The current climate of evidence-based practice urges professionals to collect, interpret and apply research findings (Johnson & Waterfield, 2004; Wynd, 2002). Phenomenological researchers communicate and demonstrate the importance of participants' accounts and investigators' interpretations by presenting results in a coherent and logically presented report (Aisbett, 2006).

The results of the study may suggest that the use of identifying those in need of compliance assistance before initiation of a medication regimen is a good practice. The reflective cognitive stance characterizes the phenomenological attitudes, or the perspectives individuals develop through reflection and analysis of their innate world-directed points of view (Sokolowski, 2000). Phenomenology requires the investigator to be aware of and open to new and

fresh perspective to phenomena by deliberately departing from habitual ways of perceiving things; it can bring about unexpected resources that go beyond the findings and outcomes (Finlay, 2009). Through imaginative variation, the phenomenological investigator explores possible meanings by looking at the phenomenon from various angles (Moustakas, 1994), which was the aim of this study, and largely accomplished. The study of this nature however can be more extensive, involving large sample sizes, other populations, and potentially never ending, for the complexities involving human behavior make a process ongoing learning an imperative.

Conclusion

The initiatives for quality improvement in geriatric health care may signify efforts to incorporate the following: These initiatives and interventions can promote healthier living and improve the quality of life in residential communities and health care facilities for older adults as well as decrease health care costs. Efforts to improve knowledge-based clinical judgment among prescribers are ongoing and include implementing or enhancing pharmaco-geriatric training and comprehensive courses in geriatric medicine. AGLS, for example, can revitalize and measure active community health among this population. The certification or recertification in AGLS can measure additional competency in geriatric care, evidence-based medicine, and evidence-based practices. The method will require multiple government health initiatives. National Association leadership initiatives to innovate and implement certification and recertification in a new American geriatric lifestyle support (AGLS) system in geriatric care (American geriatric lifestyle support (AGLS)

Future Recommendations

Future recommendations based on the discoveries from this study include the call for researchers to increase the competency of healthcare providers in geriatric practice and geriatric medicine, specific to patient soft skills. The escalating change in the geriatric population demographics and coexisting morbidities warrant further research in explicit and implicit prescribing indicators to monitor PIMs. Concerted efforts can influence academic and professional leaders, national organizations, and legislative policymakers to control and resolve discrepancies in geriatric medicine and practice. Researchers need to become stronger influential leaders in the health delivery system aspects of health care reform to prevent the prescribing of PIMs and polypharmacy.

The following finding and recommendations are a result of the extensive analysis of the study data, as presented. Future research could take place to determine if this study can be replicable with other cultures. The essential requirement for empathy and collaboration entails dialogue regarding medication compliance, which should start the first time the interaction between the physician and patient begins. The study findings have provided a clear indication of the importance of collaboration, dialog, empathy, and listening skills. As well as the qualities, imperatives to improve, increase medication compliance, and improve the success, arising from consequent compliance (Wallhagen et al., 1994; Nunes et al., 2009; Gibbon et al., 2005; Hixon, 2004; Johnston et al., 2005, as cited in Armstrong, 2007; Black & Hawks, 2005; McCuaig et al., 2012).

Training on collaboration in fostering strong patient-physician relations should be starting at the core level of medical school as part of the curriculum. Educating students regarding the high risks of noncompliance as it relates to the

elderly African Americans population regarding increased re-hospitalization, increased incidents of deaths, strokes, etc., but also costs taxpayers, and the elderly (Arendt, 2006; Elliot, 2006; McElnay, 2006; Takaki & Yano, 2006; Richardson, 2007; Rogers, 2007; Smith, 2007).

Future Medical Students

The need to look for signs and symptoms of noncompliance through a follow-up system that is a medical group team effort that entails tracking patients through monthly phone calls or even more frequent monitoring if high risk patients, is a possible area of greater future focus than currently in place. The physician would need to know when the patient either picks up the prescriptions refill, or refuses the refill order. A recommendation to include in the curriculum should also consist of resident doctor's role-playing the parts of patients with co-morbidities with underlying depression with denial of noncompliance. As indicated by all participants' answers, questions number one versus number seven where the members acknowledged feeling differences in symptoms when they did not take the medications as prescribed by the health care practitioner. For future studies of physicians having practicing privileges at any hospitals must attend mandatory in-services regarding patient's noncompliance to medications as it relates to co-morbidities with vital signs and symptoms of depression.

Recommendation to Regulators

Another recommendation is that the federal regulations by the Centers for Medicare and Medicaid Services (CMS) mandate Delphic panels of experts in geriatrics within the four geographical regions of the United States. These experts can evaluate trends in PIMs and the health status of Americans aged 65 and older. Experts must take initiative steps to modify ICD-10- CM coding to specify diagnoses of PIMs and polypharmacy. The groups develop and report measures that improve appropriate prescribing practices of PCPs and other health care providers. In conjunction with these statements are indicators for areas that need improvements or lack development continually among medication prescribers for elderly patients (American Geriatrics Society, 2012).

A recommendation derived from the analysis of the data of this study, connotes that CMS must mandate health care professionals in regions with lower reimbursement to enroll in geriatric training seminars and challenge tests. Tests should assess knowledge and awareness of pharmaco-epidemiology in geriatric medicine. Licensure regulators must mandate minimum passing scores and stipulate the certification and recertification bylaws in geriatric medicine. Innovation, adoption, and implementation of a new lifestyle support certification, defined as American Geriatric Lifestyle Support (AGLS) system, can revitalize and measure active community health among geriatric patients. The certification in AGLS will measure additional competency in geriatric medicine. Guidelines for protecting the geriatric population must reflect an ongoing contribution to society, evidence-based practices, and evidence-based medicine (Christensen, Howren, Hillis, Kaboli, Carter, Cvengros, Wallston, & Rosenthal 2010).

Recommendations for the Healthcare Industry

The recommendations for the health care industry also surfaced, as the research uncovered many areas and opportunities for improvement. The medical review board, using computer technology enforces investigations of PCPs' clinical practice of multiple prescriptions (polypharmacy) among elderly beneficiaries. The technical capability exists

for screening computerized physician order entry, (CPOE) systems by the quantity of drugs and categories of drugs for each recipient.

For precautionary purposes, computerized health information systems will flag excessive numbers of prescriptions, for example, affecting the central nervous system of elderly patients, particularly attention to stimulants (amphetamine), depressants (barbiturates, benzodiazepines, and tranquilizers), and opioids (Demerol). Health information systems monitor inappropriate use of anesthetic agents, such as hallucinogens (ketamine), and inhalants (nitrous), among geriatric patients. Pharmacotherapy, psychotherapy, and anesthesia agents have significant physicochemical properties and clinical applications for geriatric medicine (Freeman, 2006; Robert, 2006; Wagner, 2007; McHenry, Insel, Einstein, Vidrine, Koerner, & Morrow, 2012).

The FDA enforces specifications for the quantity of prescriptions and the combining of drugs, and ensuring safety and efficacy of generic and new drugs. The least safety and efficacy drugs demand removal from the consumer market. Health care leaders eliminate catastrophic prescription costs to avoid donut holes for beneficiaries with chronic diseases. Legislatures and AGS officials need to collaborate and promote policies with partnership efforts for reducing pharmaceutical costs (Freeman, 2006; Robert, 2006; Wagner, 2007; McHenry, Insel, Einstein, Vidrine, Koerner, & Morrow, 2012).

When dysfunctions of cognitive skills and psychomotor abilities develop in elderly patients, physician's requisite appropriate regimens prescribed for patient-specific comorbidities of pharmacotherapy or psychotherapy. The importance of these recommendations is the higher rate of medical illnesses, and neurologic disorders (such as hypertension, renal failure, cardiovascular disease, dementia, Parkinson's disease, Alzheimer's, and stroke syndromes) are prevalent among aging patients. Tailoring e-prescribing treatments for each patient is an essential component of health care reform to improve geriatric population health (Wallston et al., 1978; Buchmann, 1997. Gibbon et al., 2005; Hixson & Keenan, 2005; Johnson et al., 2005; Black & Hawks, 2005; Christensen et al., 2010).

Recommendations for Professional Providers:

The prevalence of potentially inappropriate medications, (PIMs) amidst the geriatric population is a critical public health concern among prescribing physicians, PCPs, surgeons, and anesthesia providers. Health care professionals must focus on patient-specific ordering for appropriate regimens, tailoring with an e prescribing, Clinical Decision Support Systems (CDSS). Surgeons' and PCPs' regimens include implementation of adequate educational materials and preventive care forums.

Polypharmacy may be appropriate to improve health for those with mental and medical comorbidities or complex medical conditions. These individuals are sicker populations of geriatric beneficiaries with cognitive, physical, and biological impairment. Evaluation programs for improvements in geriatric training for mental health and medical professionals or fellows should lie within the curriculum of academic medicine. A patient-provider relationship is a partnership and social responsibility of professional providers. The collaboration of professional providers, patients, and caregivers involves patient specific ordering of drug therapy, circumventing disparity, particularly in Medicare sicker and more costly patient care

beneficiaries (NCPIE, 2007; Traynor, 2009 as cited in Tricoche, 2012).

Recommendations for Improvement and Researchers

The escalating change in the geriatric population demographics and coexisting morbidities warrant further research in explicit and implicit prescribing indicators to monitor PIMs. The analyzes of pooled studies depicted confidence intervals to illustrate that incompetence in providers' prescribing practices and their training make geriatric patients susceptible to PIMs and polypharmacy. This present meta-analysis challenges researchers to become influential leaders in the health delivery system aspects of health care reform as efforts to prevent polypharmacy promotions and PIMs practices.

Concerted efforts can influence academic and professional leaders along with national organizations and legislative policymakers. On educational, organizational, and political levels, leaders can control and resolve the prescribing discrepancies in geriatric medicine and practices through epidemiological and human research that is compliance and results correlated. Based on the consistency of findings from this study, the potential for health informatics discernibly exists to improve primary care prescribing, and it is critical to persuading federal legislation, seize regulatory loopholes, and identify gaps in the research.

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