

Patient Compliance to Clinician Prescribed Pharmacologic Treatment in Elderly African Americans

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ABSTRACT

Willful or unintended and negligent noncompliance to the advice of a clinician and recommended prescription medication by the elderly may have widespread ramifications, and often leads to hospitalizations, and increases in home health care costs and death. The elderly in the United States, average 12.7 prescriptions per year, consume 30% of prescription medications, spend \$15 billion annually, and some receive eight or more medications per day. The focus of this qualitative study with a phenomenological design was to gain insight into the lived experiences in respect of pharmacological noncompliance. The participants for this study included 20 elderly African American individuals from Wisconsin. The research questions were framed to conform to a phenomenological study. The purpose of the study was to gain insight into the personal lived experiences of study participants in respect of medication compliance and adhering and complying with the medical advice of physician medical practitioners. Participants narrated life's story regarding a personal medical condition and the ability to adhere to the instructions of a physician. The normative decision-making theory served as the conceptual framework and reference, to gain a deeper understanding of the motivations that drive, or constrain compliance to medication. The analysis of the data took place after completion of the research. The interviews were coded, transcribed, and categorized to facilitate the analysis of the data using an appropriate software program. The findings of the study indicated that the elderly experience different challenges. The responses of participants showed that the compliance levels increased when a greater and individualized interest is taken in the patient by healthcare providers. Patients are less likely to comply with the medical advice of a physician when there is little effort made to build and sustain a caring physician-patient relationship. The findings of this study may advance understanding of compliance to medical treatment, as the quest for improving the quality of life is ongoing and continuous in the United States.

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Introduction

Patient compliance with prescribed medication often influences the relationship with the medical practitioner supervising treatment. Patients, who take an interest in personal well-being and actively demonstrate responsiveness to medical care, often respond better to treatment and have a higher rate of satisfaction in health care outcomes. The non-adherence to prescription medication by patients as recommended by a licensed medical practitioner is a growing social concern in the United States (U.S.) as cited by health professionals (Goold, & Lipkin, 1999). McLeod (2007). Prescription medication noncompliance is common among the elderly population, represents a hidden epidemic in society, and a complex problem (Vermeire, Hearnshaw, Van Royen, & Dinekens, 2000; Ward et al., 2012). Health care practitioners have some ability to obtain the knowledge of a patient's health locus of control (HLC), (DeForge, Stewart, Zhan, & Graham, 2005; Graham & Lavicka, 2010; Brown, & Bussell, 2011) and provide programs geared toward increasing awareness of the benefits of adhering to medical advice, thereby in maintaining better patient health outcomes. Successful adherence to treatment by the patient may

decrease the financial burdens for the patients as well as society (Armstrong, 2007; McCuaig, Coore, & Hay, 2012).

Background of the Study

Noncompliance to prescribed medication can be intentional or inadvertent, and unintentional, and represent not following a physician's treatment directives and plan (Chance, 2007; McCuaig et al., 2012). These directives expressed as a prescription and other instructions by a board-certified physician, or licensed medical practitioner, reflect the patients' medical care and interventions, deemed appropriate, and in the patients' health interests (DeForge, Stewart, Zhan, & Graham, 2005; Brown, & Bussell, 2011). An exacerbation of medical conditions often occurs because of noncompliance in the elderly population. Typically suffering from chronic diseases, co-morbidities, the multiple medications increase the potential for side effects, and adverse reactions (Bedell et al., 2000; Skhosana, Struthers Gray, & McIntyre, 2006; Robertson, 2007; Brown, & Bussell, 2011). A significant factor in patient noncompliance, is also sometimes attributable to the lower socioeconomic status of the elderly (Austin, 2004; Hughes, 2004; Reynolds et al., 2004; Brown & Bussell, 2011).

Polypharmacology in elderly patients is common as these individuals may first receive prescription directives from the primary physician and then from other specialists, which in turn stretches the financial resources of the individual undergoing treatment (Austin, 2004; Brown & Bussell, 2011; Rosini, 2014). Kennedy and Erb (2008) discovered 76% of patients, ages 75 and older, take three or more prescriptions per day. In this study, more than 50% of these interviewed were noncompliant, and the actions or inactions often resulted in repeat hospitalizations, increased blood sugars, or elevated blood pressures. The associated economic, financial, and medical implications arising from missed doses, sub-therapeutic dose levels, and other such consequences are costly (Foder et al., 2005; Brown & Bussell, 2011; Rosini, 2014). The elderly discard three billion prescriptions, worth \$203 billion annually. Research studies have revealed that the elderly population is linked with noncompliance to prescription medications, as exhibited by overuse, under use, inappropriate medication administrations, and the failure to refill prescriptions (Foder et al., 2005; Arendt, 2006), noncompliance is not following the health care provider's medication orders (Thompson & Walker, 2011). Self-scheduling by alternating drugs at different times than those recommended, missed one or more doses of the prescribed medication, increasing the frequency may also amount to noncompliance. Discontinuing the drugs without physician's consent would thus also constitute noncompliance with medical advice (Chia, Schlenk, & Dunbar-Jacob, 2006; Vrijens, Vincze, Kristanto, Urquhart, & Burnier, 2008).

Problem Studied

The United States Department of Health and Human Services (2007), records have denoted over 125,000 deaths per year because of patient noncompliance to physician's medical recommendations. Non-compliance may lead to adverse side effects, medication self-dosing, loss of balance, falls, leading to hip injuries and fractures. The earlier costs of \$20.2 billion annually for hospitalizations and may further cost \$34.2 billion by 2020 (Ayala, Xie, McGruder, & Valderrama, 2007; Vrijens et al., 2008). 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 (Ayala et al., 2007; Vrijens et al., 2008). The general problem is that noncompliance to prescription medication costs approximately \$1,000 billion to the United States taxpayers annually (Herrick, 2011). The specific problem is that there is little understanding of the compliance by elderly African American patients to a physician's prescription. The lack of treatment advice in the United States health care system (CDC, 2012), and patient noncompliance often results in injury or death (Chia et al., 2006; Vrijens et al., 2008).

Purpose of the Research

A phenomenological study was undertaken to gain a deeper understanding of medical compliance by elderly African American to a physician's prescription and treatment advice. The invocation of the principles of phenomenology as espoused by research experts (Moustakas, 1994; Neuman, 2003; Creswell, 2007; Tozer, Belanger, Moore, & Caudle, 2014; Leedy, & Ormrod, 2010) helped to accomplish the objectives of the study. The purpose of the study may reflect an important step in contributing to knowledge, considering the cost of healthcare to the system, taxpayer, and society.

In the study, the aim was to gain insight into the lived experiences of participants extensively. The interviews were

conducted to the point of reaching data saturation, representing the stage of diminishing returns in information, and when further interviews yielded no new information. Qualitative research is a useful approach to glean information from participants through interaction (Neuman, 2003; Leedy & Ormrod, 2010; Flood, 2010). In qualitative research, the request for volunteers to participate based on personal lived experience and ability to provide a deeper understanding of the phenomenon studied constitutes an important research consideration (Moustakas, 1994; Giorgi, 2003; Flood, 2010). The qualitative method and a phenomenological research design was an appropriate approach to address the central and sub-research questions, as the aim was to collect, analyze and organize data to facilitate a deeper analysis and understanding of the phenomenon of noncompliance. Influential researchers characterize this as the development of the actual participants' structural, textural meanings, and the essences of the experience (Moustakas, 1994; Giorgi, 2003; Flood, 2010). Repeat hospitalizations because of willful or negligent noncompliance with a medication regimen costs \$12 billion to \$15 billion yearly to taxpayers (Kenen, 2009). The findings from this research study was helpful in discovering perceived barriers that may contribute to prescription noncompliance.

Economic Impact of Noncompliance by the Elderly

Patient data and information	Economic cost and Implications	Referenced Sources
1. The elderly citizens receive an average 12.7 prescriptions per year	Cost was \$32 billion in 2006, and cumulative outlays through 2015 is anticipated to be \$797 billion	Lichtenberg & Shawn, (2007)
2. Increased in hyper/hypoglycemic episodes	Costs \$225 million annually	Kitabchi et al., (2001); Christensen et al., (2010).
3. Repeat hospitalizations because of willful or negligent noncompliance to a medication regimen	\$12 billion to \$15 billion yearly	Kenen, (2009); Christensen et al., 2010
4. Increases in hypertensive emergencies leading to heart disease	\$277.1 billion annually	Ayala, Xie, McGruder, & Valderrama,(2007)
5. Economic, financial, and medical implications and hardships relating to missed doses, sub-therapeutic dose levels, evictions relating to financial decisions about choosing between	\$100 to \$300 billion per year	Armstrong, (2010).
6. Lack of knowledge regarding their health care directives	\$50 billion to \$73 billion dollars per year.	Bartleson, (2005); Ferrario, 2008; Christensen et al., 2010.
7. Lack of medical professionals to follow up with medication adherence	Costs \$177 billion annually	American Pharmacists Association (APhA), (2004).
8. Elderly discard prescriptions	\$203 billion annually	Ayala et al., (2007).

Research Questions

The questions for this study were developed from research and reviews of relevant literature, to reflect the appropriate level of analysis and inquiry. The problem is that there is little understanding of the compliance by elderly African American patients with a physician's prescription and

treatment advice in the United States health care system (CDC, 2012). Patient noncompliance often results in injury or death (Chia et al., 2006; Vrijens et al., 2008; Fiscella, & Holt, 2008). For the study, the use of a phenomenological approach helped to gain insight into the lived experiences of elderly African American participant's opinions and thoughts regarding medication compliance. To fulfilling the aim of the study, the research questions served to explore how the elderly African Americans developed critical thinking skills regarding medication compliance. The overarching research question for the study was:

RQ1. What knowledge from the lived experiences of elderly African Americans might increase the understanding of clinicians about prescription medication compliance?

The sub-questions for the study were:

RQ2. What are the lived experiences of the African American individuals aged 75 years and older who are taking prescription medications?

RQ3. What (if at all) does the understanding of the participant's compliance relate to the prescribed medication dosage requirement?

Significance of Study

The aim of this study was to identify the cost of noncompliance to prescription medication, as it often results in frequent re-hospitalizations and other grave consequences. The findings of this study hence may be of value to medical practitioners and administrators. Health illiteracy is often a result of a lack in knowledge about patients' health care and leads to increases in-home health care costs (Sheridan, Halpern, Viera, Berkman, Donahue, & Crotty, 2011). Elderly patients have a four times higher incidence of adverse reactions to medications and errors because of the lack of knowledge of physicians about geropharmacology (Ferraria, 2008). Patient's noncompliance to a prescription regimen often leads to adverse effects, such as falls, loss of balance, double vision, heart palpitations, irritability, nausea, and diarrhea. Fall-related injuries because of hip fractures have cost \$20.2 billion annually and may cost \$34.2 billion by 2020 (Ayala et al., 2007; Vrijens et al., 2008; Fiscella & Holt, 2008).

Patient compliance with medical advice potentially results in fewer hospitalizations, and decrease medical costs to the patient as well as to insurance providers (Gibbon, Kanani, & Oliver, 2005; Black & Hawks, 2005; Christensen et al., 2010). The focus of this qualitative phenomenological study was to gain insight into the lived experiences of the elderly African American community regarding the experiences in complying with medical and pharmacologic treatments, recommended by a personal physician. The intent of the research was to also gain insight into the patient's knowledge base concerning health care literacy and assess the belief in health care locus of control in medication compliance (Bajcar, 2003; Christensen et al., 2010; De las Cuevas, Wenceslao & Sanz, 2013).

Schillinger (2007) stated that noncompliance negatively influences the elderly with multiple chronic conditions. The experience or fear of medical side effects may cause some elderly patients to cease following the prescribed medication without consulting their physicians. When some individual stops following a prescribed drug regimen and begins to self-direct their drug dosing, this may be counterproductive to the therapeutic goals of the treatment. In reported research, the medication noncompliance rates varied from, 14% to 77% (Kozier, Erb, Berman, & Snyder, 2004; Keehan, Cuckler, &

Sisko, 2012), depending on the measurement method, disease, and noncompliance factors, and cultural beliefs regarding medications. The conclusion by these researchers, was that physicians should correct the misperceptions the patient has about efficacy of drugs. The doctor then must address concerns regarding the possible adverse reactions and promote adherence to prescribed directives (Kozier et al., 2004; Fulmer, Kim, Montgomery & Hyder, 2007; Barat, Andreasen, & Damsgaard, 2001; Keehan et al., 2012).

Willful or negligent noncompliance with medical advice and prescribed medications and treatment by the elderly, may have widespread ramifications. The cost of noncompliance to prescription medication adherence is significant as it leads to frequent re-hospitalizations, and the financial burden hurts the health care system and patients respectively. Health illiteracy as a lack of knowledge about patients' health care is a contributing factor for frequent hospitalizations and increases in-home health care costs. Elderly patients have four times higher incidence of adverse reactions to medications and errors because of the lack of knowledge of physicians about geropharmacology (Ferrario, 2008; Christensen et al., 2010).

Nature of Study

Phenomenological interviews are unstructured, and the researcher and participants work together to explore the phenomenon from the first-hand experiences of the latter. Leedy and Ormrod (2010) indicated that investigators conducting a qualitative study should be comfortable with the assumptions of the qualitative tradition. Researchers must also consider the following components of a qualitative study: (a) the audience for the study, (b) the nature of the research question, (c) the extensiveness of the related literature, and (e) the intentions of the depth of what are to study and discover (Moustakas, 1994; Neuman, 2003; Creswell, 2007; Leedy, & Ormrod, 2010; Tozer et al., 2014). Researchers should determine personal willingness to interact with the people in the study and level of comfort working without much structure. Researchers should have ability to organize and draw inferences from a large body of information.

For this study, using a phenomenological research study included the analysis of interviews with the aim of identifying patterns and themes in the data. The process involved a constant comparison of the interview transcripts to identify key themes that emerged, including analysis of all experiences and perceptions conveyed. Key themes from the comparison helped to develop a narrative of the data collected from the respondents using Moustakas' (1994) modified van Kaam method of analysis, with the NVivo 10 research software (QSR International, 2007). Data collection from the participants provided an opportunity to reflect on the problem and the strategies to develop critical plans to ensure compliance until achieving data saturation. An assumption of the analysis was relevant to the meaning of the elderly African American's perceptions, the values and the purpose of applying this knowledge to community advocacy. The aim of the research questions, was to understand why some elderly are compliant with medication regimens while others are not and to understand the connectedness, if any, with the community and society.

Conceptual Framework

The conceptual framework for the study was developed using theories derived from a review of the literature, and applied to studying how elderly African Americans comply with prescribed medication. Kurt Lewin envisioned and formulated a collaborative process to elicit changes in social

behavior across disciplines such as nursing, teaching, and organizational development (Wallis, 2009). Kleindorfer, Kunreuther, and Schoemaker (1993) introduced and postulated three theories of decision-making, notably: normative decision-making theory, descriptive theory, and the prescriptive theory. The normative decision-making theory was a basis to explain how individuals make optimal decisions concerning personal health care, in the quest to achieve favorable treatment/clinical outcomes and results. The participants of the study who make normative modes of decision-making mirror individuals are internals who score high on the internal health locus of control (IHLC) scale (Graham & Lavicka, 2010; Kauffman, 2011). Individuals referred to as internals, may rely on existing experience, engage in healthy behaviors, knowledgeable about the health problems, and tend to make better choices concerning medication regimens (Takaki & Yano, 2006; Wallston, Wallston, & DeVails, 1978; Armstrong, 2010; Kruglanski & Gigerenzer, 2011).

The descriptive theory is a valuable reference to evaluate how people naturally go about the decision-making process (Graham & Lavicka, 2010). Kleindorfer et al., (1993) noted that people rarely make decisions as espoused by the normative theory. Individuals adapted simpler modes of thinking because of their processing capacity, which may lead to poor decision making. The prescriptive theory has postulated that human beings are poor decision makers and often require decision aids to assist them (Graham & Lavicka, 2010; Kruglanski & Gigerenzer, 2011). Patients often may discontinue following a prescribed drug regimen to save the prescriptions for a later date. The United States Inspector General's Office stated that 125,000 deaths per year occurred because of noncompliance with prescribed medications. Some reasons for noncompliance may be the inconvenience of side effects. Other causes for noncompliance are the patient's denial of personal diagnosis, the high cost of the prescription drugs, and the lack of clear medical instruction from the health care provider (Schillinger, 2007). The medication noncompliance rate has varied from, 14% to 77%, (Kozier et al., 2004; Keehan et al., 2012), depending on the measurement method, disease, and noncompliant factors, and intrinsic factors. Health care practitioners must address these misperceptions of the patient in efforts to enhance the effectiveness of medications and clinical outcomes. The concerns of clinicians are of patient compliance, reduce the incidence of adverse reactions, and promote adherence to a personal and specific treatment and pharmacologic regimen (Barat et al., 2001; Kozier et al., 2004; Chia et al., 2006; Fulmer et al., 2007; Vrijens et al., 2008; Keehan et al., 2012).

The goals of this study were to collect deep insights from participants on pharmacologic treatment compliance. Quantitative research pertains to the statistical analysis, trends, or methods to examine identified research projects, and focuses on the relationship of variables, and in estimating outcomes from numerical data analysis (Neuman, 2003), and hence, was inappropriate to study lived experiences. Quantitative research is not suitable to study human challenges as is more conducive to measure by using statistics, numbers, and involves a study of trends, which requires control over extraneous or outside variables that are not part a study, and is generalized (Shields & Twycross, 2003). Noncompliance is more than just missing medications it requires probing about the life experiences and reasons the elderly may decide to inadvertently, or willfully abstain from

taking prescribed medication (Blakstad, 2008; McHenry et al., 2012).

Rationale for Study Methodology and Design

A case study was not conducive to understanding the lived experiences of the elderly who are taking multiple medications as part of everyday living. In case studies, treating each participant as an individual helps in drawing cross-case conclusions. In case studies, a researcher is a passive observer, versus interacting with the participants in a phenomenological study. Hence, was not appropriate to study the lived experiences of the chosen sample for medication compliance (Blakstad, 2008; McHenry et al., 2012; Long, Mitchell, Young, & Rickard, 2014). A researcher uses a grounded theory design to study, or explain a process. Grounded theory was also 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, 2010). Ethnography and a case study were similarly 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 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 method, with a phenomenological design and approach was found suitable to fulfill the aims of this study, after extensive research. This design aided to explore and understand the phenomenon and gain first-hand information from the participants.

Definitions of Terms

The explanation and description of the concise and essential terms of the medical abbreviations, tests, and medical research, topics, medical personnel, technology, and using government agencies in the study are to provide clarity to the reader.

American Geriatric Lifestyle Support (AGLS) system: Implements and advocates programs for research, public education, policy, and patient care professional (The American Geriatrics Society, 2012)

Centers for Medicare and Medicaid Services (CMS): The center provides the total health care delivery system to promote efficiency and quality (The U. S. Department of Health and Human Services, 2011).

Chronic obstructive pulmonary disease (COPD): Closing of the airway usually associated with bronchitis, emphysema or both (Spielberger, 2004).

Clinical Decision Support Systems (CDSS): A computer system to help make clinical decision and analyze applications for health care professional (Zarkogianni, Litsa, Mitsis, Wu, Kaddi, Cheng, Wang, Nikita, 2015).

Concordance: The unwritten agreement between health care provider and patient (Dennis, 2006).

Computerized Physician Order Entry, (CPOE): Computerized entry system for healthcare professionals (Zimlichman, Keohane, & Franz, 2013).

Coronary artery disease, (CAD): Deposits of fatty acids build up in the arteries (Armstrong, 2010).

External memory: Physical environmental reminders to support memory changes, for example, list, calendars (Spielberger, 2004).

Health locus of control, (HCL): A patient's internal or external influences control over desired outcomes (Armstrong, 2010).

Internal memory strategies: Connecting concurrent activities to support memory, for example, tape recording daily activities (Spielberger, 2004).

Primary Care Physician (PCPs): Health care provider who sees the patient on a regular basis (Jerant, Kravitz, Tancredi, Paterniti, White, Baker-Nauman, Evans-Dean, Villarreal, Ried, Hudnut, & Franks, 2016).

Potentially inappropriate medications, (PIMs): Ineffective or high-risk medications given to elderly patients by the health care provider (Chan, Chen, Kuo, We, Lu, Chiu, and Wu, 2012).

Polypharmacy: Three or more prescribed medications from a health care provider (Laufs et al., 2011).

Prospective Memory: Remembrance and recall of current tasks and instructions (Gould, 2004, p. 114).

Reality monitoring: Refers to distinguishing between actions planned and actions carried out (Gould, 2004).

Retrospective memory: Past events are remembering the instructions received for when and how to take medication (Gould, 2004).

Unlicensed Assistive Personnel (UAPs): Unlicensed nursing staff member who works under the direction of a nursing supervisor to provide patient services (Lancaster, Kolakowsky-Hayner, Kovacich, & Greer-Williams, 2015).

Key Assumptions

The key assumption made in this qualitative research study with a phenomenological design was the concept that individuals have different views on society (Merriam, 2009; Leedy & Ormrod, 2010; Tozer et al., 2014) created reality in respect of personal situation and setting. Another assumption was that meaning pertinent to the phenomenon are ingrained in the experiences of participants screened and qualified, who completed the study, and provided responses truthfully. Qualitative researchers assume research is context-bound, but theories and patterns develop to produce an understanding of a phenomenon or situation (Merriam, 2009; Leedy & Ormrod, 2010; Flood, 2010). In qualitative research, the assumption is that multiple methods of data collection and conceptual frameworks serve to increase the credibility of a study by converging on the same conclusion (Merriam, 2009; Leedy & Ormrod, 2010; Flood, 2010).

Scope, Limitations, and Delimitations

A purposive sample drawn from the population for the research study included 20 elderly African Americans, taking three or more medications, under the care of a health care provider, and living in the inner city of Wisconsin. Adhering to directives from the health care provider and following a treatment plan is often complicated for the elderly experiencing cognitive difficulties, and errors interpreting medication schedules are common among patients (McDonald, 2007; Holt et al., 2012; Tomasik & Fleming, 2015). A purposive sample has the same characteristics that fit the study criteria (Fain, 2010). The site was appropriate for conducting the study 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, leads to compliance, however also presents difficulties for the patient.

Medication adherence is costly to the patient not only in the financial sense but also the medical complications of noncompliance outweigh the costs, as there are the risks of hospitalizations, infections, increase hypertension, hyper, or hypoglycemic incidents (Spielberger, 2004; Holt et al., 2012). Arguably, concerns occur when patients must take multiple prescriptions for comorbidities. Many medications come in separate blister packs, which can become bulky, and need extra storage space. The medications are difficult to transport, and rather than decrease the patient's confusion; this may increase it (Spielberger, 2004; Warren-Findlow, Seymour, & Shenk, 2010; Holt et al., 2012). Increases in adherence levels obtained from results from several studies that focused on medication compliance, indicated a positive connection between the health care provider, and the patient when the doctor takes the necessary time to educate the patient about their illness (Spielberger, 2004; Warren-Findlow, Seymour, & Shenk, 2010; Holt et al., 2012).

There are many interventions available; patients choose to be noncompliant, and compliant, no matter how tailored to the individual, adherence to a medication regimen will not occur. The elderly may stop taking their prescriptions to avoid side effects, consider that the medication is not effective, or no longer necessary (Spielberger, 2004; Warren-Findlow, Seymour, & Shenk, 2010; Holt et al., 2012). Compliance relates to the extent of the following of any medical advice by the patient. The research focus of this study was on the use of medications and noncompliance. Physicians often hear of various reasons for nonadherence, and these include not having a prescription filled, and not following dosage directions (Donovan, 1992; Warren-Findlow, Seymour, & Shenk, 2010).

The scope of a study may reflect certain boundaries of the study. This study was limited to a sample drawn from the congregation in Wisconsin. Another limitation potential was researcher bias. The significant aims and strategy was to remove personal bias from the study because of involvement in the healthcare industry for years. Matching the perceptions of the interview responses and not introducing one's individual bias (e.g., through body expression, the exclamation of personal feelings, or interrupting when administering the interview questions) remained essential for this research study to mitigate any researcher bias. By reviewing interviewing techniques, the skills acquired helped to make participant feel unhurried and relaxed in answering the interview questions truthfully. Some participants did digress from the subject at times and had to refocus with prompts and the interview guide aiding in steering the conversation to the interview. The delimitations were necessary for the study. The delimitations represented the geographic location, boundaries, and comprised of the elderly African-American members of the Lutheran Church congregation. The exclusionary criteria for participants included the following: participants under the age of 75 years, only those taking three or more medications per day, Caucasians as well as other ethnic groups, and ex-patients were excluded.

The limitations of the study are the weaknesses and per this definition, and served to also identify the potential weaknesses of a study and those that were uncontrollable. The restrictions of the participants for this study were limited to the elderly African American members the church only.

Replications of answers to the questions are other limitations to this qualitative study, as each participant had personal experiences to a similar health diagnosis i.e. diabetes, hypertension, and other ailments typical of advancing age. The study results may have the potential to apply to all elderly African Americans.

Review of Literature

The literature review consists of research findings related to the qualitative phenomenological study regarding the noncompliance of patients to the medication regimens using ProQuest and EBSCOhost databases, as well as a review of regulatory and other credible health resources and websites.

Historical Overview

The aim of the qualitative study was to gain insight into the lived experiences of elderly African Americans study participants regarding their ability to ensuring compliance with personal prescribed medical treatment. The details include a critical review of literature related to the theme of the research study on the successes and failures of patient compliance with prescribed drug therapy. The incidence of hypertension is lower in Caucasians when compared to African-Americans, organ damage, early onset and greater severity. American adults, 33% have increased blood pressure, but 50% control personal hypertension per the current clinical guidelines. Further studies may help to determine why several patients from this group are not getting the necessary health care as required by the current guidelines (Yazdanshenas et al., 2014)

A study of 400 African Americans, aged 65 years, recruited from 16 African American churches located in South Los Angeles, and included face-to-face interviews, documenting, frequency, type, and dosage medications used by participants. The study results revealed that treating HTN with diuretics therapy, along with an angiotensin converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), calcium channel blocker (CCB), or conventional beta-blocker (BB) was the correct combination of therapeutic drugs for treating and maintaining high blood pressure. The discovery of at the end of the study indicated that the management of hypertension appears to be inconsistent with management of hypertension with the guidelines for the elderly African American population needs further study to understand why this number of this population are being not being served per the new guidelines (Flack, Sica, & Bakris, 2010).

In 2010, a team of doctors from the International Society on Hypertension in Blacks, (ISHIB) submitted a medical report that identified new goals for blood pressure levels for this population. The new ISHIB blood pressure levels 115/75 mm Hg. African Americans at risk 135/85 mm Hg. African Americans high risk is 130/80 mm Hg (Flack, Sica, & Bakris, 2010). The American Diabetes Association new guideline for blood sugar levels is between 70- 125 mg/dL after fasting, or after eating, which is considered normal. Medications, exercise and changes in life style may include a combination to keep blood sugar levels within normal levels (Flack, Sica, & Bakris, 2010). 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, and 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).

In focus groups, for this study, participants reported feeling more competent about self-care and highlighted the positive impact of the CHW in motivating them to manage their conditions and comply with treatment regimens (U.S. Department of Health and Human Services Office of Minority Health, 2014).

B) Better dietary practices: Participants increased the average number of days in the past week in which they followed healthy dietary practices, from 3.63 at baseline to 4.01 after program completion. Examples of healthy dietary practices include eating more fruits and vegetables, spacing carbohydrates throughout the day, lowering intake of high-fat foods, not adding salt to foods, and avoiding canned and prepackaged foods (U.S. Department of Health and Human Services Office of Minority Health, 2014).

C) More physical activity: Participants increased the days in the past week in which they engaged in physical activity 30 minutes per day, from 3.50 at baseline to 4.74 after the program (U.S. Department of Health and Human Services Office of Minority Health, 2014).

D) More foot care: Participants with diabetes showed a significant improvement in foot care, with the average days of which they performed such care increasing from 3.79 at baseline to 5.41 after the program (U.S. Department of Health and Human Services Office of Minority Health, 2014).

E) Better medication adherence: Participants with diabetes showed a slight improvement in adherence to their medication regimen, with the average number of days in the past week when they took recommended medications increasing from 5.29 at baseline to 5.87 after the program (U.S. Department of Health and Human Services, 2012).

Important Study Findings

The Center for Disease Control, a U.S. agency that is charged with tracking and investigating public health trends stated that heart diseases, stroke, and diabetes, are the leading cause of disability and death (Center for Disease Control and Prevention (CDC) 2009a; Laufs et al., 2011; Lynch, Fernandez, Lighthouse, Mendenhall, & Jacobs, 2012). In the United States, four out of five older Americans have at least one chronic condition, an average of 48% of age 65 or older have three or more chronic conditions, and 21% have five or more (Norris et al., 2008). By 2030, approximately 70 million Americans will reach age 65 or older, increasing the need for health care services (Traynor, 2008 as cited in Tricoche, 2012; U.S. Census Bureau, 2008).

Adults age 75 and older may adhere less to a medication treatment plan than younger adults (Grocki & Huffman, 2007). In the aging process, the major problems are mostly sensory, motor, and cognitive (Greengard, 2009). Memory problems or cognitive impairment could affect patients' willingness to take medication as prescribed (Howland, 2007). Cognitive impairment is an important clinical issue because it occurs in half of the population age 65 or older. By the age of 85, 50% of people will develop some degree of cognitive impairment such as memory loss (Barbhaiya et al., 2008). Medication non-compliance because of cognitive impairment in older adults is a major health care problem, frequently resulting in treatment failure and poor utilization of resources (Grocki & Huffman, 2007).

In the United States, approximately 10 million people age 50 or older have osteoporosis. An additional 34 million Americans have low bone mass density, placing them at risk for fractures (Chestnut, 2006; Kothawala, Badamgaray, Seonyoung, Miller, & Halbert, 2007). By 2020, the number of hip fractures could triple with the increasing age of the population (Chestnut, 2006), and by 2030, the number of hip fractures worldwide is expected to increase six million per year (Papaioannou, Kennedy, Dolovich, Lau, & Adachi, 2007).

Following the investigation of 19 studies published in the 1950s and 1960s, Stimson (1974) discovered that noncompliant patients were described as 'defaulters', 'disobedient', 'uncooperative' because patients were not 'obeying' instructions. However, Stimson questioned the underlying assumption in these studies, that patients were passive recipients of medical instructions. Rather than accepting the notion that patients ought to receive instructions, Stimson (1974) believed that patients had independent ideas about illness and the use of medicines, which patients brought to the medical encounter. Stimson suggested that the focus of research should be on the social context in which illnesses are experienced and treatments used (Stimson, 1974; Ballard, 2004; Bajcar, 2007).

Stimson (1974) also questioned the non-participatory patients regarding compliance, using interviews and found that the decisions about taking drugs came through lived experiences and medical encounters. Discussions with lay social networks and previous experiences with other drugs also weighed into the decision mindset of patients (Elliot, Ross-Degnan, Adams, & Gelb-Safran, 2007). Stimson's respondents often described how, consulted with the health care provider, a patient has sought further information, speaking with friends, and family members about the treatment. Rather than simply disobeying the health care provider's instructions, therefore, patients using the information gathered to help inform decisions about the use of medicines (Ballard, 2004; Ingram, 2010).

Numerous researchers have failed to link consistent results to age, gender, social class, and marital status and the linkage to drug compliance. Young people are less likely to be compliant, while some researchers have indicated that the issues of noncompliance are because of the interaction between provider and patient. (Ballard, 2004; Ingram, 2010). Parsons noted, that a prerequisite of the "sick role" is the patient must be compliant with the health care provider's orders, and those who are noncompliant, are deviant. This relationship factor corresponds with Parsons' (1951) vision of the need to maintain social order through the adoption of specific social roles. (Ballard, 2004; Ingram, 2010). One way of measuring noncompliance is by calculating the difference between the number of prescriptions issued, and the pills that patient takes. Urine testing and pill counting resulted in 7% of the participants in the study as noncompliant to the prescribed medication regimen. For example, 30% of patients are noncompliant with antibiotics, and 70% of patients are not compliant with certain drugs for arthritis (for example Celebrex, Celexa, Duragesic patch, Doxepin), (Neuman, 2003; Ballard, 2004; Rosner, 2006; Liu et al., 2010; McKinzie, 2010).

Older adults are more likely to take multiple medications for chronic illnesses (Kocurek, 2009; Norris et al., 2008; Snowden, 2008), and as the number of pharmacological drugs increase patient adherence tends to decrease, potentially

leading to lack of control of the disease (Cornell, 2009). Non-adherence tends to increase in patients with multiple chronic health conditions (Williams, 2007). The prevalence of hypertension is greater in the African American population compared to Caucasians and Mexican American populations (Ostchega, Yoon, Hughes, & Louis, 2008). Hypertension increases with age, affecting more men than women (Varon, 2008), and despite medical advances in treatment and public information efforts, hypertension remains an important health issue in the United States (Ostchega et al., 2008). In the aging process, elasticity in the artery decreases and the level of blood pressure increases. Hypertension is sustained or elevated blood pressure, and often becomes a major risk factor for other chronic conditions, such as heart failure, stroke, and coronary artery disease (Holt, Muntner, Joyce, Webber, & Krousel-Wood, 2010; Laufs et al., 2011; Lynch et al., 2012; Holt et al., 2012). The treatment of hypertension in elderly adults has reduced cardiovascular diseases and death (Langan, Bordelo, & Ghetu, 2009).

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). The researchers who conducted the study entitled Diabetes, Attitudes, Wishes, and Needs (DAWN), (Delamater, 2006) noted, that diabetics have problems adhering to a medication regimen because of poor psychological well-being. The DAWN study indicated that the identification of psychological problems by many health care providers makes them uncomfortable because of a lack of experience (Scheppers et al., 2006). Diabetic control and complication trial were successful in achieving good glycemic control. Factors that promote adherence, include phone calls to patients' upcoming appointments and reminder postcards (Scheppers et al., 2006).

Many researchers have also delved into the wider social context of drug administration. For example, Conrad (1985) discovered that patients with epilepsy self-regulated medicines to ensure normality and to live what they consider to lead a normal life. Helman (1981) described the classification of long-term users of stimulants based on personal perspectives, symbolic meanings, and modes of use. Patients hold personal beliefs about seeking treatment and medication advice and are active in the treatment decision; the term compliance becomes problematic. The concept of conformity helps to expand on the idea that it is rationale for patients to adhere to medical advice. The concept denies the legitimacy of behaviors that deviate from the practitioner's instructions. The idea of concordance needs to be developed (Horne et al., 2005).

Patients who do not follow through with the health care practitioner's directives may face the risk of frequent hospitalizations. A complex prescription plan may cause non-compliance due to the possible confusion to the patient. A deterioration of physician-patient relationship because of the lack of trust, and adverse effects on the patient's health, such as the increase in pain, may also be factors associated with non-compliance. The efforts of research in the past seemed focused on determining numerical figures for compliance and failure, and the profiles of patients (Rosner, 2006; Grocki & Huffman, 2007; Kocurek, 2009), rather than qualitative views.

Alternative Viewpoints

The literature review includes a discussion related to some of the reasons for noncompliance by elderly African Americans to a health care provider's advice and may also denoted gaps in literature stemming from the lack of studies on this topic (Agyemang, Addo, Bhopal, & Stronks, 2009). Negative patient-health care provider relationship, language barriers, fear of embarrassment, regarding the medication regimen, and the lack of medical knowledge related to their health condition (Roster, 2006; Hansen, 2007). There are currently many studies with a focus on patient's perceptions on the personal health and medical services and qualitative research relating to the doctor-patient interactions (Agyemang et al., 2009). Patients from ethnic minorities have identified a language barrier as factors, and administration which affected healthcare and research findings, shed light on some behaviors, cultural, and beliefs, that might have affected help seeking and compliance (Haskard, Zolnierok, & DiMatteo, 2010).

A lack of commitment to follow through with the treatment and the reasons for noncompliance are often a result of changes in lifestyle, and the discomfort of the treatments associated with some treatments side effects (Rosner, 2006). Patient-physician dissension often stems from miscommunication, noncompliance, and poor quality of care, observed in research studies (Barton et al., 2011, p. 35). The effort to improve the quality of health literacy accomplishes strong health informational skills and the ability to function adequately in a health care environment (Healthy People, 2010). There are factors, such as age and race that are finite in socio-demographic settings, there are factors as illegal drug use, smoking, educational level, drinking, abstract poverty that affects the ability to obtain quality health care. The lack of insurance coverage or underinsured is a barrier for compliance for medical treatments prescribed by the physician, as the cost of prescriptions is enormous, on a limited, or below poverty level (Scheppers et al., 2006)

Armstrong (2010) stated the construct of health locus of control (HLC) theory is the belief that external internal, and a level of control over outcomes, influence the state of the person's health. The health locus of control theory consists of three dimensions: internal, powerful others, and chance. The internal component and aspect of the theory reflect personal responsibility, which potentially affects health status (Hawks, 2005). Patients' have a higher dependency on others, such as caretakers, spouses, or on their adult children. The HLC theory connotes a patient's ideology that a loss of health is because of destiny (Wallhagen et al., 1994; Nunes et al., 2014; Gibbon et al., 2005; Hixon, 2004. Johnston et al., 2005, as cited in Armstrong, 2007; Black & Hawks, 2005; McCuaig et al., 2012).

The decision-making process for voluntary compliance to medical treatment and adhering to the instruction and directions of a medical practitioner appears often governed by the patient's internal and external factors of health care locus of control. The knowledge from the findings of this study may help health care practitioners encourage patients to make positive choices and decisions in respect of complying with the physicians recommended medical treatment guidelines and prescription. This decision-making process may be worthy of exploration in future studies to understand why some patients comply, and others do not adhere to a health care practitioner's medical treatment directions and advice (Wallston et al., 1978; Buchmann, 1997; Gibbon et al., 2005;

Hixon, 2004. Johnston et al., 2005, as cited in Armstrong, 2007; Black & Hawks, 2005; McCuaig et al., 2012).

Kleindorfer et al. (1993) introduced and postulated three theories of decision-making: normative decision-making theory, descriptive theory, and the prescriptive theory. The normative decision-making theory can be a basis to explain the actions and behaviors of individuals who are rational decision makers. The normative decision-making theory has posited that people are well informed and use their knowledge in decision-making alternatives to guide choices. The beliefs and preferences associated with the alternatives, individuals often take the rational and best course of action to optimize that course of action, to achieve favorable results. The normative mode of decision-making mirrors people who score high on the internal health locus of control (IHLC), (Graham & Lavecka, 2010) are called internals. Internals rely on existing experience, engage in healthy behaviors, knowledgeable about the health problems, and tend to make better choices concerning medication regimens (Takaki & Yano, 2006; Wallston, Wallston & DeVeils, 1978; Holt et al., 2012).

The descriptive theory is a valuable reference as it can be the basis on how people naturally go about the decision-making process. Kleindorfer et al. (1993) noted that people rarely make decisions as espoused under the normative theory. Individuals adapt simpler modes of thinking because of personal processing capacity, which may lead to poor decision making. The prescriptive theory author has postulated that human beings are poor decision makers and often require decision aids to assist them. The descriptive theory postulations give insight into how individuals make decisions and the propositions of the prescriptive theory indicates how people can make even better personal decisions with assistance (Holt et al., 2012)

Barons' (1999) study consisted of one hundred and thirty-three participants and measured indecisiveness using 11-item questions, which ranged from general indecisiveness regret 5-item proneness, to regret when making and evaluating decisions, maximization 13-items measures the disposition to maximize when making decisions. The Bas/Bis scales 20-items have four factors, one reflecting the sensitivity of the Behavioral Activation System; Behavioral Inhibition System Bas/Bis (e.g., "I worry about making mistakes," (Baron, 1999; Holt et al., 2012). Three reflecting dimensions of the sensitivity of the bas, including drive (e.g., "if I see a chance for something I want, I move on it right away," (Baron, 1999; Holt et al., 2012), fun seeking (e.g., "I often act on the spur of the moment," (Baron, 1999; Holt et al., 2012). Reward responsiveness (e.g., "when good things happen to me, it affects me strongly," (Baron, 1999; Holt et al., 2012). These subscales are important and among these are the conceptual differences (Baron, 1999; Smiley, Jackson, & Dalgleish, 2007; Holt et al., 2012).

Participants completed the information, measured by random order and the scales individually (Baron, 1999; Smiley et al., 2007; Holt et al., 2012). Using maximum likelihood estimation and Promax rotation to determine the dimensionality of the indecisiveness scale, included using an exploratory factor analysis (EFA), and invoking to maximize factors loadings on two equally important factors, while aiding the examination of any correlation of factors. In this study, a two-factor model of indecisiveness that may be superior to the one-factor model that has been assumed in the extant literature on indecisiveness, suggested an exploratory

factor analysis of the indecisiveness scale (Baron, 1999; Smiley et al., 2007; Holt et al., 2012). Brown and Bussell, (2010) stated that heuristics is the simplistic way of thinking and when deciding on risk and uncertainty may not necessarily yield favorable outcomes. Heuristic thinking could lead to poor decision making because of the misperceptions of the risks. Similarly, stating a problem, for example if emphasizing gains rather than losses, could affect the risk-taking propensity. Emotional states such as stress, fear, and a lack of connection with the problem could engender the use of suboptimal decision-making strategies. When people have the resources of experience and expertise from which to draw from, they tend to make decisions in very different ways.

Barat et al., (2001), stated 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 et al., 2011; Holt et al., 2012). The patient noncompliance rate varies from, 14% to 77%, depending on the measurement method, disease, and noncompliance factors, such as memory, coping, problem-solving skills, psychosocial factors, and cultural beliefs regarding medications. The conclusion of Barat et al., (2001), the study was that physicians should correct the misperceptions the patient has about the effectiveness of efficacy of drugs. The doctors then must address concerns regarding the possible adverse reactions, and promote adherence to prescribed directives (Kozier et al., 2004; Fulmer et al., 2007; Laufs et al., 2011; Keehan et al., 2012).

A degree of complexity in the lives of the elderly African American sample appears to cause patients' not to adhere to treatments recommended by their health care provider (Ballard, 2004; Laufs et al., 2011). Many impinging influences may prevent patients from adhering to prescribed therapy regimens, such as lack of finances, inability to travel to obtain prescriptions, fear of leaving the house because of the neighborhood, fear of being robbed. Practitioners should not overlook the role of the church as a collaborator pertaining to the problem of adherence regarding prescribed medication regimen. The role of the African American church has an influence on the community and the factors of individual or collective cultural influences.

Research Method and Design Rationale

Qualitative research is valuable to bring the social aspect of life to the fore, and for the researcher to consider the experiences, interactions observations visual and historical context of a person's life (Van Kaam 1984). Phenomenological research is an in-depth interview from description to experience by the individual (Creswell 1998), which helps to understand the implications of personal experience (van Manen, 1997). Husserl and Gibson (1931) noted phenomenology research dates to the writings of Edmund Husserl. The phenomenological design, within a qualitative research method, serves to obtain a complete description the individual reflects on an organized analysis that portrays the experience (Moustakas, 1994). Researchers including Schutz (1977), Merleau-Ponty (1962), and Giorgi (1980) indicated that phenomenologists concentrate on understanding human experience and the interpretation of an experience. Understanding how people apply knowledge to experiences, construct the world, and the meaning of a situation gives credibility to a study.

Exploring perceptions and lived experiences of a population may signify a phenomenological approach to research (Leedy & Ormrod, 2010). Yildirim (2010) identified qualitative research as an approach, which served to focus on the study of social contexts using the underpinning of an appropriate theory. Individual perceptions and lived experiences, behaviors, emotions, feelings, and language are the ideal foundations for exploring cultural events, situations in society, and social movements (Yildirim, 2010). Phenomenology is a research design within a qualitative research setting, where the intent is to recognize and delve deeper into exploring the phenomenon, to understand the significance of the event on study participants in respect of personal lived experiences (Converse, 2012; Arvidson, 2015).

Quantitative research often pertains to the statistical analysis, trends, or methods to examine projects, and assess by manipulation of the variable, and evaluate outcomes, (Neuman, 2003). As this numerical-based approach would not serve to understand human phenomena, the method was considered inappropriate to study lived experiences and not chosen as a research option for this study. Quantitative research was also not suitable to study human challenges, as is more conducive to measure by using statistics, numbers, and involves a study of trends or general tendencies, which requires control over extraneous or outside variables that are not a part of this study (Shields & Twycross, 2003). Noncompliance is more than just missing medications it requires probing into the life experiences and factors regarding the elderly decisions to willfully decide or abstain from taking prescribed medication (Blakstad, 2008; McHenry et al., 2012).

A case study was not conducive to understanding the lived experiences of the elderly who were taking multiple medications as part of everyday living. In case studies, treating each participant as an individual helps from the drawing of cross-case conclusions. In case studies, a researcher is a passive observer, versus interacting with the participants in a phenomenological study. Hence, a case study was not appropriate to study the lived experiences of the population, and the purposive and sample for medication compliance, in congruence with the views of many researchers cited herein (Blakstad, 2008; McHenry et al., 2012; Long, Mitchell, Young, & Rickard, 2014). The aim of the study was to understand and gain insight into the lived experiences regarding compliance with individual prescribed medical treatment plan, and involved participants narrating personal life stories and experiences about managing a medical condition.

Thematic Analysis of Interview Data

The research questions aimed at obtaining insights into patient's views and lived experiences of the spectrum or reasons and challenges, ranging willful and inadvertent compliance to noncompliance. The interview questions were open-ended and designed so that the participants shared personal lived experiences in trying to achieve and maintain compliance. The interview questions using an Interview Guide enhanced the ability to use a semi-structured interview process, and that the underlying question remained the same, and that was to gain insight into the lived experiences of the elderly African Americans regarding medication compliance. Further organizing the numerous answers that resulted from the triangulation process, reorganizing the themes into smaller groups to increase data manageability and significance; and implementing these steps aide in the

uncovering of substantive meaning in the pathway of discovering and meeting the study objectives.

Research Questions

The overarching research question for the study was:

RQ1. What knowledge from the lived experiences of elderly African Americans might increase the understanding of clinicians about prescription medication compliance.

The following are the sub-questions for the study:

RQ2. What are the lived experiences of the African American individuals aged 75 years and older who are taking prescription medications?

RQ3. What (if any) does the understanding of the participants of compliance relate to the prescribed medication dosage requirement?

The United States health care system (CDC, 2012) noted, that noncompliance resulted in injury or 125,000 deaths per year (Chia et al., 2006; Vrijens et al., 2008). The research questions developed from research and reviews of relevant literature may reflect the appropriate level of analysis and inquiry. The problem is that there is little understanding of the compliance by elderly African American patients with a physician's prescription and treatment advice in the United States health care system (CDC, 2012). Patient noncompliance often results in injury or death (Chia et al., 2006; Vrijens et al., 2008). For the study, use of a phenomenological approach helped to gain insight into the lived experiences of elderly African American participant's opinions and thoughts regarding medication compliance.

Geographical Location of Study and Sampling Method

The purpose of this qualitative study was to understand the lived experiences of 20 African American individuals aged 75 years and older. The criteria for selecting participants included the requirement of taking medications prescribed by registered medical practitioners and conducted using residents from a large city in the state of Wisconsin, in the United States, with the details of the sample selection from the congregation of a church. Understanding how people apply knowledge to experiences, construct the world, and the meaning behind a situation gives credence to qualitative research (Yildirim, 2010).

The participant selection criteria for this study was purposive, and included 20 elderly African Americans age 75 and over, currently under the care of a medical health care professional, taking three or more medications and members of the church of an inner-city congregation. Burns and Grove (2007) definition of population is individuals meeting certain criteria for inclusion in a study. In this study, the invocation of purposeful sampling helped to identify individuals who met the study participation inclusion criteria, for the in-depth interview, to gain an enhanced understanding of the phenomenon. Qualitative researchers select data sources using purposeful sampling, which is a nonrandom method. In purposeful sampling, researchers choose participants who will produce the most information about the topic under inquiry (Leedy & Ormrod, 2010). For the study, the rationale for using nonprobability sampling hinged on the premise that with this technique, researchers choose participants because they are available, convenient, and possess characteristics relevant to the study.

Role of the Researcher

The role of the researcher was to serve as the primary instrument in data collection. Engaging in the interview process required transparency and clear boundaries. Nurses must listen empathetically, ask probing questions, practice

reflection, and clarify respondent interactions (Bulpritt & Martin, 2010). Keeping in mind the research process was an interview which develops an understanding of the lived experience of the elderly African Americans compliance with medication compliance. The research technique was a phenomenological described by Moustaka (1994), and based upon audio-recorded and transcribed interviews using semi-structured questions to capture the perceptions, and the lived experiences.

Instrumentation

In qualitative phenomenological research studies, the commonly used instrument for collecting data is the semi-structured interview (Patton, 2007). The open-ended Interview Guide for the study based on the core research questions and the researcher is the primary instrument in qualitative studies (Merriam, 2009). The design of the research questions is consistent with a phenomenological design and formulated to gain insight into the lived experiences of elderly African Americans in personal efforts at complying with prescribed pharmacological treatment. The participants had the opportunity to review the interview transcripts and the interpretation to increase rigor, in keeping with the technique of member checking, aimed at enhancing credibility and dependability of the results. Member checking may be the most important technique for demonstrating credibility (Lincoln & Guba, 1985). Member checking was undertaken for the following reasons:

1. Provides the opportunity to assess intentionality—what it is that the respondent intended—by acting in a certain way, or providing certain information.
2. Gives the respondent an immediate opportunity to correct errors of fact and challenge what are misinterpretations.
3. Provides the respondent the opportunity to volunteer additional information.
4. The respondents recording as having said certain things and having agreed to the correctness of the researcher's recording of them.
5. Provides an opportunity to summarize—the first step along the way to data analysis.
6. Provides the respondent an opportunity to give an assessment of overall adequacy in addition to confirming individual data points (Lincoln & Guba, 1985, p. 314)

Interview Guide

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

1. How would you describe your experience with following your treatment plan?
2. What stands out in your mind about some of the most significant memories in this treatment?
3. How has your medical condition altered your life?
4. How would you describe your interaction with your physician and medical staff?
5. What are some of the important thoughts on the way you cope with your medication?

Ethical Considerations

Applying the specific measures helped to ensure confidentiality. The ability to protect confidentiality and anonymity increased participant confidences to remain confident in the researcher. 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). Participant confidentiality denotes that any personal and identifying information, such as names or other distinguishable characteristics about the identity will not be on the research manuscript. Coding of participant's responses ensures personal privacy. The confidentiality provisions 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 will be in the sole custody of the researcher. 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.

Reliability and Validity in a Qualitative Context

Carefully chosen quality measures in data collection and analysis represented the strategies to increase reliability and validity in a qualitative context. Validity refers to the trustability, creditability, defensibility and plausibility of research (Johnson & Christensen 2004). Within qualitative study, validity is being able to distinguish between participant's insight and the opinion of the researcher (Choudhuri, Glauser, & Peregoy, 2004). The truthfulness of the research is internal validity, and external validity centers upon the generalizability of the findings from the research (Anfara, Brown, & Mangione, 2002).

Within qualitative research, four constructs evidence a study's level of trustworthiness (Lincoln & Guba, 1985). Elements that may test internal and external validity, reliability, and objectivity are (a) credibility, (b) transferability, (c) dependability, and (d) conformability. The trustworthiness of a study is bound to the ethical processes and implications associated with data collection and analysis (Rossman & Rallis, 2003). A qualitative study is considered good if conducted ethically (Merriam, 2009). As described earlier, measures to ensure trustworthiness, credibility, and dependability in this study became the singular focus, as the aim was to conduct a high-quality study and gain deeper perspectives into medication noncompliance. Member checking and scrutiny for accuracy ensured meeting the stated goals of trustworthiness.

Reliability refers to the constancy or regularity of results within a similar situation (Neuman, 2003). Reliability is using an instrument to measure something more than once by obtaining these same results (Bernard, 2000). Reliability is a requisite for validity within research and provides a test for the replication of a study (Lincoln & Guba, 1985; Neuman, 2003). Establishing reliability within the exploration of human sciences is challenging because people are dynamic and subjective beings (Merriam, 2009). In qualitative research, considering that reliability is an absolute sense because the interplay between the data collector and the participant is unique and thus it is impossible to replicate (Holloway, 1997). The focus on reliability within a qualitative study is non-replicable and unachievable (Lewis & Ritchie, 2003). The sample for this study was small, and

claims of generalizability cannot be made, nevertheless, it may be reasonably assumed that the findings will hold true to a similar population and setting, since the problem of medication noncompliance is often one of human failing and is unfortunately costly to the healthcare system and a burden to the taxpayer.

Trustworthiness in a qualitative study is important and the equivalent of validity in a qualitative context (Priest, 2002; Shank, 2006). Trustworthiness is equal to the degree of accuracy and honesty reflects in information collected from the studies participants (Macnee & McCabe, 2008). Developing a rapport with the volunteers' in this study, expressing interest in personal experiences, reassurance of confidentiality protocol for data collection helped to increase the trustworthiness of data collected, consistent with the advice of knowledgeable researchers (Macnee & McCabe, 2008). The transcription and data analysis is the responsibility of the researcher. The process of participant checking included confirmation of the transcribed data following the process of member checking. The reproduced data shown to the volunteers for review and revisions made from member feedback where necessary to enhance the accuracy of the data. Participants approved the transcripts before data analysis to assure the accuracy of the transcript. After the members read the transcripts and approving the copies, the next step was entering the information into the NVivo software to code the transcribed data into themes.

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 interpretation of 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). Informing respondent's that 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).

Bracketing

The researcher's role in qualitative research is to identify and monitor the potential for bias. Prior beliefs about a phenomenon are bracketed to ensure nothing interferes with the structure of the phenomenon under investigation (Converse, 2012; Merriam, 2009), and adopting this approach helped in the study to set aside any possible personal biases. The aim of the process is to reach the essence of the meaning of experiential learning and cultural competence when reaching out to marginalized populations in society. The interview process was the primary method of data collection. In the bracketing, the researcher must 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) started collecting data until saturation occurred, which is an accepted practice in qualitative research. Moustakas (1994) outlined a three-phrase, seven-step process for analyzing the rich and descriptive data gathered in a qualitative phenomenological study. The reason for the use of this procedure of data collection was the nature this study. The approach adopted in this study following Moustakas' (1994) four-step version of van Kaam's seven-point analysis respectively.

For this study, invoking the Epoche or bracketing process involved putting aside the researchers' personal experiences, feelings, values, judgments, attitudes, and beliefs regarding the relationship between leadership style and participants' commitments. To establish reliability and yield consistent results, a standard format served in conducting semi-structured interviews, and the audiotape interviews. Each interview question 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 was determined by the reoccurrence of themes, after conducting face-to-face interviews with 20 volunteers, who met the prescribed participant selection inclusion and exclusion criteria. The abundance of the data collected from participants led to the generation of composite descriptions of the many reasons for noncompliance, through the lens of participant perspectives. 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).

In bracketing of personal experiences and opinions, the focus was to view events through an innovative perception, to revisit the experiences, by abstaining from any possible preconceptions, a strategy suggested by influential researchers (Giorgi, 1997). 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 was the inherent nature of this study. The approach adopted in this study followed van Kaam's seven-point analysis and Moustakas' (1994) four-step version respectively.

Data Collection

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 asking the questions. Open-ended questions facilitate the researcher's quest to probe participants for additional information and ask for clarification. Critical thinking of the researcher fosters the research to move from specific to abstract categories and concepts (Merriam, 2009). Interview questions were used to promote rich descriptive data significant to the topic under investigation. Despite the use of semi-structured research questions, provisions for the alteration of questions provide the required flexibility to facilitate participants sharing the full story of personal experiences of the bracketed question (Moustakas, 1994; Shank, 2006). Latitude is when asking questions in semi-structured interviews (Shank, 2006).

The participants were invited to focus on the experience and moments of awareness and impact, and then to

adequately describe the experience. The aim of the interview process was to create rich, meaningful, substantive descriptions of the lived experiences of the phenomenon. The initial script and interview questions went through a process of field-testing to ensure adequacy and readability of the questions for the participants.

Recording and Transcribing. The transcribing the interviews took place on the same day, to aid in accurately describing 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 cataloging and coding. Providing a copy of the transcription of the interview for the participant to review for clarification, additions, and omissions, and sign and return was a part of the confidentiality agreement.

The participants were "debriefed" in the study, as the volunteers were encouraged to ask questions about the study (Daymon & Holloway, 2011). Debriefing of the participants provided the time and opportunity to discuss the experiences shared. In peer debriefing, an impartial team member uses a checklist to correct errors and avoid misinformation and misinterpretation, and this approach was used to aid in ensuring the validity of the data. Upon completion of the interviewing process, the data analysis phase began. The interviews were transcribed, coded, and categorized to facilitate the organization and the coding of the data, also facilitated by using the NVivo qualitative data analytical software program. Patterns and common themes extracted from the interview responses increased understanding of medication compliance by elderly African American patients to a physician's prescription and treatment advice. As stated, to ensure the protection of the data and the confidentiality of participants, a filing cabinet stores all data associated with the study, including interview transcriptions, participant consent forms, and researcher has custody of all files.

Data Analysis

The data analysis in the study involved the researcher in verifying the data by listening to the recordings and comparing to the transcripts. The data assembly for each interview session included coding of each study participant, by using the audio recorders alphanumeric file naming, as a measure to ensure confidentiality and anonymity in the recordings. Participants clarified and endorsed the interview transcripts for accuracy and received a copy. Data coding and categorization followed. Data reduction involved classifying and assigning a code to categorize the data into themes and patterns using a process of constant comparison. Storing, organizing, and determining patterns took place with the aid of NVivo 10, qualitative data analytical software, immediately after the participant confirmed each transcript for accuracy. Repeated trends and themes emerged as patterns in the data were illuminated. Data preparation and analysis procedure followed the steps laid out by Moustakas (1994, pp. 120–121) using the modified Van Kaam Method. The NVivo10 computer software is a valuable tool to facilitate data analysis (Bass & Avolio, 2007). The steps involved in the data analysis were (a) importation of interview transcripts (copy) from rich text into 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, finding patterns, and (h) generating a report.

The use of the features of NVivo 10 software led to the generation of a high level of data with the uploading of the interview transcripts, upon coding and placed in nodes, or the holding containers for thematic analysis, a feature of the software. The concept in achieving data saturation with the appropriate sample for content is validity (Francis et. al., 2010). Data saturation fulfillment is for word prevalence, node identification, and theme emergence and the sample size for this study led to data saturation upon completing of all scheduled interviews. After a constant comparison of interview transcripts, themes emerged from a careful review of participant's discussions to the questions. The questions presented an ideal opportunity to explore the study topic. Upon determination and analysis, critical issues help to establish the nature of the phenomenon (Creswell, 2007).

Study Findings and Results

The purpose of this qualitative, phenomenological study was to explore the lived experiences of African Americans 75 and older, regarding noncompliance with their health care provider's medication regimen, which is a significant cause of mortality, and for which there is limited clinician understanding. The theoretical perspectives derived from reviewing the literature regarding factors affecting the elderly African Americans choices and abilities to comply with prescribed medication.

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 of prescribed medication compliance, while using open-ended questions and served to gain insight into the factors that facilitated, or hindered patients who comprised of the sample, in keeping to personal physician's medical treatment plan.

For this study, data was gathered over a two-week period, and collecting the data through one-hour taped interviews, during which volunteers were encouraged to share their experiences, personal feelings, opinions freely, and no second interviews were necessary to obtain data saturation. Collecting a variety of types of data provides a better understanding of the phenomenon of interest and helps to identify common themes in the study. The analysis of qualitative research entails a verbatim description, to reflect on the dynamics of the interview, which may facilitate an in-depth analysis and thoughtful review of the data collected (Young, Ritchie, Laschinger, & Wong, 2007). The interview questions for this study served to generate the type of qualitative data suitable for the phenomenological method required in this study. After the tape recordings transcribed into Word documents and analyzed, copies of transcripts given to participants for approval, corrections, or edits. There were five pages of transcription from each interviewee. Storytelling serves as a valuable technique in understanding the relationship between social processes, cultural values, personal experiences, and promote understanding of a notable phenomenon (Burns & Grove, 2007), the invocation of this approach facilitated deeper responses from the study participants, consistent with the aims of phenomenology.

Demographic Data of Sample

Age range and gender played a key role in capturing vibrant information. The 20 participants responded with interest and met the criteria for the research study (see Table 1). Participants interviews based on availability. The ages of the participants ranged from 75-89 years of age. Participants openly volunteered the information freely as high school graduates and ex-military personnel.

Table 1. Participant Demographics.

Participant	Age Range (years)	Gender
P1	75	Male
P2	88	Female
P3	83	Female
P4	76	Male
P5	78	Male
P6	81	Female
P7	79	Female
P8	86	Female
P9	80	Female
P10	82	Male
P12	77	Male
P13	80	Female
P14	82	Male
P15	79	Female
P16	83	Male
P17	89	Male
P18	84	Male
P19	82	Female

Some details collected on participant demographics other than the age criteria of 75 years, may add to the knowledge generated in the study, and may provide insight into any possible nexus with abilities and challenges of medication compliance. Analysis of the data included extracting revealed perceptions, attitudes, and opinions regarding the elderly African American and their decision to comply or not comply with their health care provider's medication regimen. The next step was the data presentation focusing on the reduction and elimination of redundant and vague responses that were insignificant and listing every quote that was relevant to the experience.

The research questions used, 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.

Organizing the numerous answers from the interviews that resulted from the triangulation process, then reorganizing the many themes into smaller related groups, helped to increase data manageability and significance, and this led to the uncovering of substantive meaning in the pathway to meeting the study objectives. The NVivo 10 software generated a high level of data with the uploading of the interview transcripts, upon coding and placement in the holding containers of the software, specially related features to facilitate visualization of the data for thematic derivation and analysis. The concept achieving of data saturation with the appropriate sample for content may depict validity (Francis et. al., 2010), and the focus was ensured by having specific eligibility criteria for selecting participation in the study by individuals who met the study requirements. It took interviewing all 20 participants to reach data saturation, since noncompliance is a very personal lived experience.

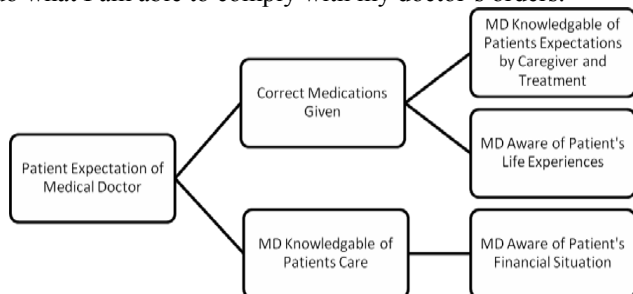
Many common themes emerged from participant discussions and responses to the questions. The clearly framed questions using the consistency of the Interview Guide, were an opportunity to explore the study topic systematically and fully. Upon determination and analysis, critical issues then established the nature of the phenomenon (Creswell, 2007) and were true of this study as well. The emergence of themes from a process of constant comparison led to the following major themes, with the accompanying illustrative process of thematic derivation also shown:

Theme 1: Patient Expectations of Physician's

Ensuring that the correct medications given ranked highest among the concerns at 57.1%: This concern expressed vocally and emphatically, is evident in the following interview excerpt: "There is no point is spending that kind of money on medication if I'm not going to take it, or don't need it." "My old doctor misdiagnosed me with diabetes because he read the wrong chart and thought I was a man, and was prescribing Metformin for high blood sugars for eight months, and I was passing out." The importance of physician knowledge of the patient was next the focus of attention and analysis. One participant stated, "Relating my life experiences should have been more prominent in my initial consultation with my doctor to ensure correct medications are given." On knowing the patient, another patient suggested, "The doctor would need to know the person they are dealing with and therefore it is important for him to know about my experiences with taking my medications."

The knowledge of the physician in respect of the personal history, economic circumstance was emphasized in the interviews: "The doctor would need to know the person they are dealing with."

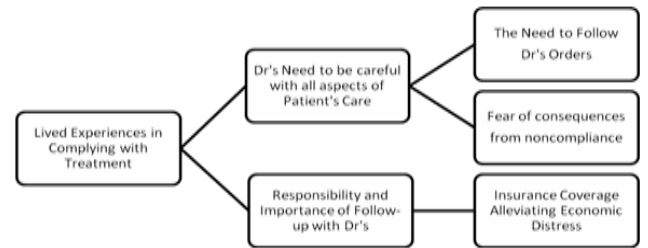
"If something has happened in my life that affects my decision to take my medicine, the doctor should know about it. For example, sometimes I don't take all my drugs because I don't have the money to buy them, or I skip a day so I can save them, until I have enough money to pay the rent my bills or buy my medications, because my social security doesn't go far enough." Participants also stated, "That doctors should be aware of patient's expectations of them and what limitations and restrictions they have regarding the number of pills per day and frequency in which they take them. "I am willing to do what I am able to comply with my doctor's orders."



Theme 2: Complying with Treatment Plan

The most critical aspect of the study was in understanding of patients in complying with the physician's directives and treatment plan and the interviews analyzed herewith. Participants provided some illuminating answers when responding to the question: "What stands out in your mind about some of the most significant memories in this treatment? How has your medical condition altered your life?" The themes, which emerged regarding life experiences and the associated concerns, as developed using the technical capabilities of NVivo software. In studying participants responding to questions regarding physician and patient's

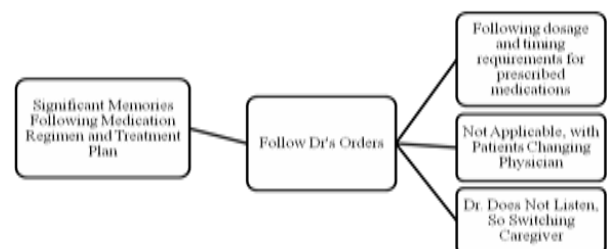
collaboration regarding health care needs, 52.4% stated, that doctors need to be vigilant and careful with all aspects of patient care." Participants, specifically 27.3% expressed that health care providers must ensure patients are taking medications and must follow-up. While admitting personal responsibility to complying, 13.6% noted that participants need the importance of following the doctor's orders as critical for better outcomes. The fear expressed by 4.5%, from losing a limb, having a stroke or death viewed as important reasons to drive compliance, and Insurance 4.5% paying for medication included some important reasons also attributed to compliance since that took over some of the personal economic burden and stress of paying out of pocket.



"I know that I am doing the right thing about following my doctor's orders was 52.4%. I don't feel good when I don't do as my doctor told me to do, and I don't feel just right." From the research, indicators showed that the more comprehensive the diagnosis of the patient, fear is decreased, reflected in 4.5% of views expressed while a higher percentage of patients stressed the importance of physicians and the supportive care to ensure patients do take the medications at 27.3%: "I went to see my endocrinologist, he asked me how long I had the lump, I was sent to the hospital, and it was scanned and drained. It had nothing to do with my endocrinology appointment, so that was memorable, and I thanked him for that."

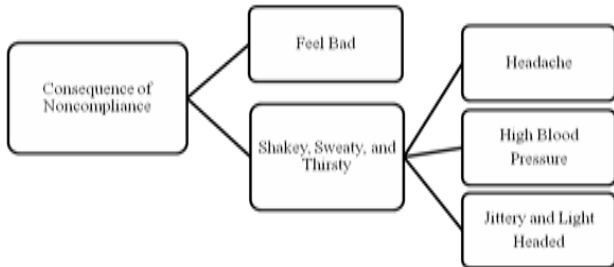
Theme 3: Significant Memories

Regarding memories pertaining to a personal medication regimen and the communication between the health care provider and themselves the results are as follows. The participant's answers indicated that overall, 66.6% follow the doctor's orders, while however following the dosage and time requirement of taking the medications orders was 16.6%, therefore denoting some deviation from developing a plan, in accordance with clear directions. Responses as Not applicable at 11.1% stemmed from participants having "fired" health care providers, and changed physicians, cited as participant displeasure arising from the doctor not listening, and reflected in views expressed by 5.2% of those interviewed. "Because I am not ready to meet my Maker just yet, and I believe, God will heal me, if I do my part and follow the doctor's orders." Following the doctor's orders denoted 66.6%. views of the participants However, with a 16.6% compliance rate, following directives is not always the case when following the doctor's orders: "Everyone's lifestyle doesn't confirm to how he prescribes medication".



Theme 4: Reasons for Noncompliance and Consequences

Asking the participants to elaborate on the consequences and implications of noncompliance to a medication treatment regimen, and the responses provided some significant reasons. Participants in response for failure to comply with treatment and medication regimens cited some important reasons as feeling reported by 28.6%, Shaky, sweaty, and thirsty 28.6%, Headache 20.4%, High blood pressure 14.3%, Jittery and lightheaded 7.1%. The responses to the question: what are your experiences when you miss your medication, as opposed to when you do not? Yielded interesting perspectives: “I take my medication, but I don’t take it correctly.” Discomfort cited presented and important reason for compliance: “When I don’t take my medication correctly I get very bad headaches and I get dizzy” 20.4%.



Another participant stated, “My medication, I only miss occasionally miss my cholesterol pill, but I always take my blood pressure medications, and diabetic meds,” which may signify that patients are aware of the therapeutic specifics of the drug and the relative importance of each.

Again, this awareness reflected in understanding the importance of a diuretic: “Oh let me tell you if I don’t take my water pills, my feet start to swell.” Further indicia of repercussions of non-compliance (i.e. shaky, sweaty, and thirsty feeling bad) reflected in patient responses.

Theme 5: Consequence of Compliance

The aim in next part of this issue was to elicit participants’ responses regarding taking medication correctly, regarding dosage, and timing, and as directed. The Participants answers regarding compliance with medication regimen daily and the responses included the positive benefits reflected as follows: Feel good 55.6%, do not miss medication 22.2%, Calms me 11.1%, and Nothing Happens 11.1%. 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 6: From your experience, what can be better in terms of your treatment?

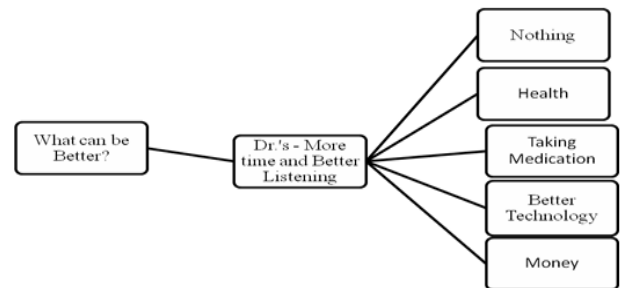
From the participants’ perspectives on what can be better with their interaction with the physician and in keeping with the importance of obtaining first-hand information on patient-centric care, responses to this question brought forth some good suggestions: “Doctors need to spend more time and have better-listening skills when dealing with the elderly

patients. They rush us through like cattle.” The responses indicated the importance of listening: 28.6%, doing Nothing 23.8%. Personal responsibility reflected in Taking Medication 19.0%, and managing personal Health 19.0% and Money came in as a major economic factor: “It’s hard making ends meet, especially when there’s more month left after the money runs out and I still have to buy my medication.” Improvement in technology at 4.8% received mention: “The doctors need to come up with better technology cause it hurts to keep sticking my finger in times a day just to check my blood sugar, and my fingers are getting numb.”4.8%.

One participant stated, “Doctor’s need to spend more time and have better listening skills when dealing with elderly patients. They rush us through like cattle.” if patients indicate that physicians are not listening to their needs, the patient may feel that they are not correctly diagnosed. The participant’s perception that the doctor is not listening to them may lead to noncompliance. “After all, why should I spend all this money on medicine which my doctor prescribed for me when he doesn’t understand me?” While one stated with finality, “The only thing that could be better for me is my money.

Participant’s responses as to “what can be better regarding their treatment?” Most seemed pleased with doctors’ treatment, reflecting 42.9%. Doctors need to listen better 19.0%; others cited Health 14.3% while better and efficacious Medication received an identical 14.3%, view: “My relationship with my loved ones could be better, but they think this is all in my head, and I’m nuts.”

The value of insurance seemed an economic savior: “The cost of medication is high, and if it weren’t for insurance I wouldn’t be able to afford my medication.”



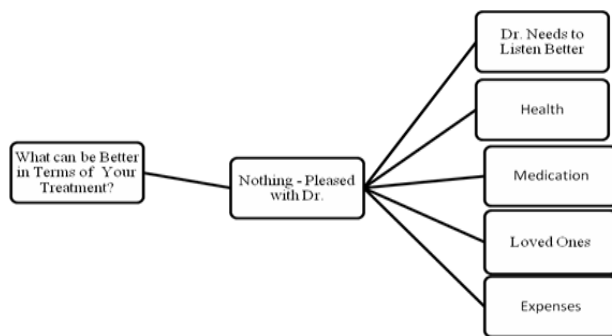
Theme 7: What are you often pleased with regarding your treatment, and what should be better?

Most participants were satisfied with personal health care providers, representing 42.9%, although many expressed that they would like to improve the doctor’s bedside manners. One member’s reflection is here: “More compassion from doctors and bedside manner. They should teach that in school.” The primary indicator in question 10 revealed that the patient feels better about compliance when the doctor is available and present during the examination. Another participant stated, “I am pleased that when I see my primary doctor, they are open and caring and responsible. My longest wait has been ten minutes.” Participants with chronic disease stated, “I should be connected to a specialist upon request, and better networking for holistic care.”

The participants said they were satisfied with the health care provider. As the responses to this question reflect members’ satisfaction to the health care providers and the overall inference, however from the participant response to this issue reflected a common theme emerging from this study in commonly found expectations and ideas across this

study, notably in listening skills, compassion, and empathy and support for the patient.

Presentation of Results



The experiences and meaning gathered from the participants during the interview process and transcriptions provided insight into the participant reasons for compliance. The individuals participating in this study indicated that 57.1% believed that the correct medications are given to the patients, signifying deep trust in physicians. The personal knowledge of doctors of patients seemed important, as 14.3% stated that the physician should know their patients, and 14.3% indicated that physicians should be aware of the patient's expectations of their patients. In the interviews, 9.5% participants stated that doctors should be aware of their patient's life experiences, and lastly, 4.8% expect physician's to be aware of their economic situation their patients face on a regular basis.

From the participants' response to the various reasons for compliance or noncompliance with physician medication regimen, the clear indication indicated a heavy emphasis on the empathy expectation of doctors. The extraction of themes from the interviews analysis of transcripts, using the technical features of NVivo shed light into many diverse and common perspectives associated with noncompliance. The costs to the taxpayer and the healthcare system remain an economic burden, however of greater value may be the knowledge to patient well-being in maintaining the quality of life of the elderly through the potential contribution of this study.

Conclusion and Recommendations

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, 2008). Through imaginative variation, the phenomenological investigator explores possible meanings by looking at the phenomenon from various angles (Moustakas, 1994). 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 responses of participants showed that the compliance levels increased when a greater and individualized interest is taken in the patient by healthcare providers. Patients are less likely to comply with the medical advice of a physician when there is little effort made to build and sustain a caring physician-patient relationship.

As stated, this open-ended question opportunity offered opportunities to discuss an important, however perhaps a less researched phenomenon, from which some valuable themes and knowledge emerged. Lastly, to conclude consistent with the undertaking of a quality study, the debriefing of participants ended the question, and answer period. After the study, all the participants received a typed transcript of personal responses for approval, with opportunity for additions and amendments.

The discoveries and findings of this study may be of significance given the paucity of information on the lived experience of elderly African Americans about medication compliance. Participants in this study provided pertinent information regarding the challenges in attempting to maintain and achieve compliance, which may offer some critical thoughts to healthcare providers and physicians, and those responsible for treating elderly patients, in enhancing medication compliance, to improve the treatment outcomes and quality of life of the elderly. 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.

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, unlicensed assistant personnel, and physicians, 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).

Reflections and Discussion

A few important points to the limitations, to supplement the discussion. Firstly, the involvement of participants narrating personal experiences in face-to-face interviews with no time restrictions, lead to individual expressions of challenges encountered and associated with compliance with the health care provider's medication directives. Phenomenological research can pose some limitations, for although there was ample time to discuss noncompliance, and compliance, many participants wanted to discuss the upcoming holidays, exchange recipes, share memories of family gatherings of past holiday traditions, and skillfully steering the conversations called for personal skill and training.

Another limitation was the reliability of measurement techniques of medication compliance such as the participants self-reporting, drug interactions or side effects. Also, difficult to measure is the patient-health care provider relationships, language barriers, fear of embarrassment regarding medication regimens, and self-regulating, which may further endorse that the limitations expressed received consideration in the analysis of the data. The limitations notwithstanding, the valuable information generated in the study may provide the insight and knowledge, which may facilitate clinical leaders to develop programs to affect positively compliance strategies and decision-making in the treatment of elderly African American patients.

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