

DISSERTATION

OLDER ADULT PATIENT-DOCTOR COMMUNICATION REGARDING ALCOHOL USE:
A QUALITATIVE STUDY

Submitted by

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ABSTRACT

OLDER ADULT PATIENT-DOCTOR COMMUNICATION REGARDING ALCOHOL USE: A QUALITATIVE STUDY

Problematic drinking is a significant issue within the older adult (65+) population. Although proper assessment and diagnosis is crucial in addressing problem drinking in this population, research suggests that physicians are not adequately discussing alcohol use with their older adult patients. In the midst of the accumulated knowledge on older adult patient-doctor communication, a sizeable gap exists regarding communication older adults report to their primary care physician regarding alcohol use. Using qualitative methods, the purpose of the present study was to understand the communication between community-based older adults and their physicians regarding their alcohol use. Results revealed several older adult biases that prevent them from initiating alcohol communication with their physician, including perceived lack of problem with alcohol, physician disinterest in the topic, completing the information on the initial intake form, and past experience with alcohol. However, participants stated that they would feel comfortable discussing the topic if initiated by their physician, and identified several physician characteristics that would improve the patient-doctor relationship, including humor, length of time with physician, perceived adequate time, perceived knowledge, and similarly aged.

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Chapter 1: Introduction

Problematic drinking is a significant issue within the older adult (65+) population (Berks & McCormick, 2008). According to the annual national survey on drug use and health sponsored by SAMHSA (2009), 50.3% of individuals between the ages of 60-64 years used alcohol in the past month, and 39.7% of individuals 65 and older used alcohol in the past month. Six percent of adults aged 65 and older reported binge drinking and 2.2% reported heavy drinking. Binge drinking was defined as five or more drinks in the same occasion on at least one day in the past month, and heavy drinking was defined as five or more drinks on the same occasion on each of five or more days in the past month. Research suggests that 9% of community-dwelling older adults with Medicare report unhealthy drinking (Merrick, Horgan, Hodgkin et al., 2008).

Given the changing demographics of the older adult population, it is estimated that alcohol use among older adults will only worsen. Estimates from the 2000 U.S. census indicate that adults aged 65 and older represent 12.4% of the population, and it is predicted that this percentage will increase to 19.6% by the year 2030 (Moore, Karno, Grella et al., 2009). If the rate of alcohol abuse remains unchanged, there will be approximately 50% more older adult alcoholics at the end of the 21st century than at the end of the 1970s (Fink et al., 2001). Due to the large population size and high substance use rate of the baby-boom cohort, the number of adults aged 50 and older with substance use disorders is projected to double from 2.8 million in 2002-2006 to 5.7 million in 2020 (Han, Gfroerer, Colliver, & Penne, 2009).

Contributing Factors to Older Adult Alcohol Use

Research has identified some potential stressors that contribute to the likelihood of an older adult using alcohol (Norton, 1998; Barnea & Teichman, 1994). These include unstructured time (Norton, 1998; Solomon et al., 1993), loss (Barnea & Yrividmsn, 1994; King et al., 1994;

Norton, 1998), loneliness (Dupree, 1990; Norton, 1998), and irrational beliefs (Boggs & Leptak, 1991; Erickson, 1963; Norton, 1998).

Unstructured time. In the United States, it is customary for individuals to work to the point of retirement. In many cases, a person's view of self has been heavily related to that individual's occupation or work within the home (i.e., raising children). Further, time up to the point of retirement has typically been structured. Once retirement has been reached and children leave home, much of the previous focus has been lost. Lack of activity, or perceived unimportance of activity, can escalate into feelings of loneliness (Norton, 1998). The perceived lack of meaningful structured activity can be difficult for an older adult. These feelings can lead to the presence of depression, loneliness, boredom, overwhelming stress, the burden of caregiving, or chronic pain, all of which have been identified as triggers to symptoms of addiction (Solomon et al., 1993).

Loss. A major trigger for depression in older adults is multiple losses (Norton, 1998). Losses in older adults may involve loss of identity at retirement, friends through death or relocation, standard of living, social status, health, cognitive functions, motor abilities and functions, vigor, sexual drive and/or performance, meaning of life, interest in things previously valued, one's spouse, and empty nest syndrome (Norton, 1998). Loss of spouse has been identified as especially critical (King et al., 1994). These natural losses can give rise to many negative thoughts and feelings. The use of substances can become a means to cope with the difficulties of loss (Barnea & Teichman, 1994).

Loneliness. Many factors can impact the number of friends and social support of an older adult, which may create a sense of loneliness (Norton, 1998). First, illness can limit the way individuals interact with each other. Second, loss of friends through death or relocation can be a

major factor contributing to loneliness (Norton, 1998). An older adult may be forced to move to a different part of the country for health benefits, and some may be reticent to make new friends after such an uprooting (Norton, 1998). There is evidence that loneliness and depression can contribute to using alcohol as a coping mechanism (Dupree, 1990; Norton, 1998).

Irrational beliefs. Erickson (1963) identified the final stage in his identity developmental process as “integrity versus despair.” In this stage, the person reviews the totality of life and decides if it was worthwhile or worthless. Those who view their lives as having integrity seem to adjust well to older age and retirement and are not at high risk for using substances (Norton, 1998). The coping mechanisms utilized in earlier years that brought them to the position of integrity are thought to also serve them as an older adult (Erickson, 1963).

Individuals who view their lives with despair are ones who tend to experience irrational beliefs. Examples of irrational beliefs include: “I am too old to change,” “I must inevitably suffer because of my reduced mobility and/or health status,” “I am dependent on others, I am a worthless person” (Norton, 1998). Irrational beliefs are thought to involve guilt over a negative life review or as a defense against unpleasant conditions in the person (Boggs & Leptak, 1991). Alcohol and other substances may be taken as self-medication to lessen the negative cognition (Norton, 1998).

Negative Consequences of Older Adult Alcohol Use

Research has identified several consequences of older adult alcohol use (Merrick et al., 2008; Moore, Whiteman, & Ward, 2007). These include problems with health (Merrick et al., 2008), negative reactions with medications (Moore, Whiteman, & Ward, 2007), and increased mortality rates (Adrian & Barry, 2003).

Health problems. Problem drinking patterns are important given the negative impact of alcohol on health with age. Older adults' higher sensitivity and poorer ability to metabolize alcohol contribute to high risk at a given level of use (Merrick et al., 2008; Saitz, 2003). The misuse of alcohol by older adults can lead to cirrhosis of the liver, peripheral neuropathy, depression, late-onset seizure disorder, confusion, worsening dementia, poor nutrition, incontinence, peptic ulcer disease, and inadequate self-care (Fink, et al., 2001). Two to three drinks per day have been associated with hypertension and diabetes; as few as one to two drinks per day can increase the risk of hip fracture and breast cancer (Adrian & Barry, 2003; Holbrook, Barrett-Connor, & Winegard, 1990; Reid, Boutros, O'Connor et al., 2002; Willett, Stampfer, Colditz, et al., 1987). Further, alcohol can exacerbate medical disorders that are common in older adults, including congestive heart failure (Saitz, 2003). Alcohol use and misuse can also increase the risk of hospitalization and nursing home placement among older adults (Reid & Anderson, 1997). Older adults are hospitalized for conditions associated with alcohol at approximately the same rate as for myocardial infarction (Adams, Yuan, Barboriak et al., 1993).

Medication reactions. Approximately 90% of older adults use prescription and over-the-counter medications, and many medications interact adversely with alcohol (Reid & Anderson, 1997; Reid, Boutros, O'Connor, et al., 2002). Older adults are susceptible to adverse effects from the combined influence of alcohol and medications because of changes in the body with increasing age that affect the distribution and metabolism of these substances and increase the brain's sensitivity to their effects (Moore, Whiteman, & Ward, 2007). Moore et al. (2007) reported that 19% of older adults consuming alcohol took at least one medication that could have negative interactions with alcohol.

Older adults who drink alcohol and who take medications are at risk for a variety of adverse consequences depending on the amount of alcohol and the type of medications consumed. Types of risks include increased blood alcohol content (BAC), increased and/or decreased drug metabolism, disulfiramlike reactions, multiple health problems, and interference with the effectiveness of medications (Moore et al., 2007).

Mortality. Alcohol use among older adults has been associated with excessive deaths from accidents and suicides, violent death, traffic accidents, and unnatural causes (Adrian & Barry, 2003). The majority of these findings were based on studies of mortality, by using information on causes of death of alcoholics or high-level drinkers. Alcohol use can also cause falls leading to hip fracture, a leading cause of death in this group (Merrick et al., 2008).

Primary Care Physician Role

Proper assessment and diagnosis are crucial in addressing problem drinking in an older adult population (Sorocco & Ferrell, 2006). Research consistently identifies primary care physicians as being best positioned to identify potential alcohol abusers of all ages (Johnson et al., 2005; Buchsbaum, Buchanan, Poses, et al., 1992; Levin, Sullivan, & Fleming, 1998). This is due to the fact that primary care physicians treat a majority of the population, and up to 45% of patients report a history of excessive drinking. As a group, older adults tend to visit primary care physicians more frequently than younger adults, and approximately 87% of older adult patients regularly see a primary care physician (Nemes et al., 2004; Ross, 2005). SAMHSA (2005) suggested that adults over the age of 60 be screened for alcohol-use problems on a regular basis, preferably at their yearly physical.

Alcohol use disorders among older adults are often under-diagnosed, misdiagnosed, undertreated, or untreated (Han et al., 2009). Health professions tend to overlook alcohol use

disorders among older adults, often mistakenly attributing the symptoms to other common problems among older adults, such as dementia/Alzheimer's disease, depression, and other health problems (Sattar, Petty, & Burke, 2003).

Attitudes held by physicians and other health practitioners may contribute to alcohol use problems being overlooked. Physicians may be likely to avoid the topic of alcohol use because it can be a difficult topic to discuss with patients. Specifically, physicians are less likely to screen for alcohol use in older adults, women, the educated, and those with a higher socioeconomic status (Sorocco & Ferrell, 2006). Physicians believe that it is not necessary to screen for alcohol-related problems in older adults because these patients cannot be treated "successfully," or the time and energy required to treat substance abuse is too great for patients who are so close to the end of their life span (Ross, 2005). Sharp and Vacha-Haase (2010) found that physicians who held negative perceptions of their alcohol management skills with older adults (i.e., ability to diagnose and treat alcohol use problems) were less likely to screen their older adult patients for alcohol. Many physicians fear that discussing alcohol use with their older adult patients would spoil the relationship (Arborelius & Thakker, 1995). Some physicians have a condemning attitude towards "excessive drinkers," which can be related to previous negative experiences of treating patients, or a stereotyped view of what would constitute an "excessive drinker" (Arborelius & Thakker, 1995, p. 421).

Patient-Doctor Communication

Previous research has addressed physician communication, screening, and diagnosis with older adults about their alcohol use focusing on how to improve these practices with older adult patients (Brower, Mudd, Blow, Young, & Hill, 1994; Buchsbaum, Buchanan, Poses et al., 1992; Johnson, Booth, & Johnson; 1995; Sattar, Petty, & Burke, 2003). However, physician screening

is only as good as the information patients report. Older adults may experience increased emotional discomfort when visiting doctors, may have age-related memory deficits that interfere with the reporting of symptoms, and may be suffering from increased anxiety in general, possibly contributing to reluctance to discuss alcohol use with their physician (Gastel, 1994; Hocking, 1995; Weitzman & Weitzman, 2003). In particular, middle-aged and older women often feel dissatisfied with the quality of communication with their physicians (Adler, McGraw, & McKinlay, 1998; Weitzman & Weitzman, 2003). Some older adults believe that not questioning their physician is necessary for good healthcare, and asking too many questions can be perceived to be potentially antagonistic to doctors (Adler et al., 1998; Weitzman & Weitzman, 2003). In addition, many older adults often simplify or focus on one element in order to fit in with their expectations of consultation and the capacity of the physician to help in a time limited managed care appointment (Peters, Rogers, Salmon et al., 2008). Patients often describe their doctors as having dualistic explanations where psychosocial factors could not coexist with the physical ones. By disclosing psychosocial concerns, such as alcohol use, patients believe they risk diverting physicians from thoroughly considering physical causes associated with their symptomology (Peters et al., 2008). Moreover, patients fear that explicitly discussing the possibility that a symptom has a psychosocial cause could lead physicians to attribute any future symptom to psychosocial causes, without investigation. Therefore, many patients consciously withhold psychosocial issues from their primary care physician (Peters et al., 2008).

Reason for Current Study

In the midst of the accumulated knowledge on older adult patient-doctor communication, a sizeable gap exists regarding older adult communication about alcohol use to their primary care physician. This leads to the question, “How comfortable are older adults in sharing their alcohol

use with their primary care physician?” Although the current literature suggests that older adults are more likely to hide their alcohol use problems and are less likely to ask for help than younger adults (Brower et al., 1994), the research is limited.

A personal understanding. Beyond wondering about patient-doctor communication questions that are unanswered in the literature, there are several other reasons for the current study that have been undeniably present throughout the process, from research design, to interviews, to interpretation, to defense presentation.

This topic originated from the researcher’s personal interest in older adult alcohol use and previous research on the topic. In particular, the researcher performed a previous study that explored older adult alcohol use and became aware of the gaps in literature that existed with this population. A multitude of literature exists for adolescent and alcohol use; it was disappointing how uneven the literature was distributed in regards to age and those in their later years.

There is also a personal connection to older adult alcohol use. An individual that is very dear to me used alcohol to an unhealthy level. It is unclear whether anyone talked to this individual about their use. It is also unclear whether or not this individual would have made different decisions given proper information. However, every individual deserves to have the knowledge that is necessary to make decisions regarding their use. I believe the source of this type of information is the primary care physician.

Each of these reasons for conducting the current study influenced the research process, and it is important to make these reasons explicit, in an attempt to acknowledge the biases and values inherent in them, as these have undoubtedly been present in the study.

What is qualitative research?

Prior to a discussion of the philosophical tenets of phenomenology, it is important to address the philosophical assumptions of qualitative research. Researchers make certain philosophical assumptions in qualitative research, which consist of a stance toward ontology, epistemology, axiology, rhetoric, and methodology (Creswell, 2007). The views endorsed in these areas create the groundwork for how qualitative researchers approach the research question, data collection, and interpretation.

The issue of ontology relates to the researcher's stance toward the nature of reality and its characteristics (Creswell, 2007). Qualitative research embraces the idea of subjective realities, which means there is not one, true reality for all people. Therefore, multiple realities exist and qualitative researchers conduct studies with the intent of reporting these multiple realities (Creswell, 2007; Willis, 2007).

Epistemology is concerned with what we can know about reality and how we can know it (Willis, 2007). In the qualitative tradition, the researcher is an active agent in acquiring knowledge and will construct her own understanding of the research study. To do this, qualitative research attempts to minimize the distance between those being studied by conducting research in the field (Creswell, 2007).

All researchers bring unique values to a study, and the axiological assumption addresses the role of values within a qualitative study (Creswell, 2007). A qualitative researcher acknowledges the value-laden nature of the study because she can never completely separate herself from the project. As a result, researchers actively report their values and biases in their report (Creswell, 2007). Continuing to compare and contrast exercise between qualitative and quantitative research, quantitative researchers generally assume that their work is value-free and unbiased.

In the preceding paragraphs, the paradigm assumptions inherent in qualitative research have been highlighted. The following sections include descriptions of phenomenological qualitative research specifically.

Interpretative Phenomenology

Phenomenology is a qualitative research method originally developed by Edmund Husserl, and is concerned with the ways in which human beings gain knowledge of the world around them (Wertz, 2005; Willig, 2001). It recognizes the subjective nature of experience and seeks to understand the world as it is experienced within particular contexts and at particular times, rather than in abstract statements about the nature of the world in general (Willig, 2001). The aim is to develop a “composite description of the essence of the experience for all of the individuals” (Creswell, 2007, p. 58). Phenomenology is concerned with understanding and describing this essence, rather than explaining it.

Interpretative phenomenology is a version of phenomenology which continues to capture the quality and texture of individual experience. However, it recognizes that such experience is never directly accessible to the researcher (Willig, 2001). Thus, interpretative phenomenology emphasizes that research is a dynamic process with an active role for the researcher in that process (Smith & Eatough, 2006). The researcher’s values will always be present, and the final phenomenon that is reported will always be the researcher’s interpretation of the study participant’s stories (Willig, 2001).

It has been suggested that interpretative phenomenology may have particular relevance for health psychology (Brocki & Wearden, 2006). Researchers are recognizing the importance of understanding patients’ perceptions of and interpretations of their bodily experiences, and the meanings which they assign to them. Thus, interpretative phenomenology allows researchers to

explore subjective experiences, such as older adult alcohol use, and helps to describe and understand the respondent's account of the processes by which they make sense of their experiences (Brocki & Wearden, 2006).

Purpose of the Present Interpretative Phenomenological Study

Understanding how older adult individuals discuss their alcohol use with their physicians can facilitate improved patient-physician communication, reduce high-risk drinking in older adults, and enhance quality of life (Brower et al., 1994). Interpretative phenomenology provides the richest and most descriptive data and thus is the ideal research process for eliciting this type of information. Thus, the purpose of this study was to understand the communication between community-based older adults and their physicians regarding the patient's alcohol use.

Research Questions

How do older adults experience communication with their primary care physician about their alcohol use? This was the central research question for the current study. This question was purposefully broad and open-ended. Based on documented barriers to older adult patient-doctor communication (Peters et al., 2008; Weitzman & Weitzman, 2003), the following subquestions were developed to help to narrow the focus from the broad central question.

- 1) How comfortable are older adults in discussing their alcohol use with their primary care physician?
- 2) What fears, if any, do older adults have about communicating their alcohol use with their primary care physician?
- 3) What factors would facilitate or hinder communication about their alcohol use?

Chapter 2: Methods

Participants

Eleven individuals participated in the study. Participants were eligible for inclusion in the study providing they were aged 65 and older, currently used alcohol, and had an identified primary care physician. The sample consisted of fairly equal representation of male and female participants, 45% and 55% respectively, with an average age of 79 ($SD = 5.35$) years. The majority of the participants identified as White/Non-Hispanic ($n = 10$) with one individual identifying as Multiracial. All participants reported a minimum educational attainment of high school, and a majority of the participants reported being married ($n = 9$), with two being widowed. Participants reported, on average, using alcohol almost three days per week ($M = 2.91$, $SD = 1.51$), with approximately two drinks per occasion ($M = 1.45$, $SD = .69$). In regards to their primary care physician, the average length of care was eight years ($M = 8.05$, $SD = 9.35$) with an average of two visits per year. Overall, participants reported having a positive relationship with their physician based on a Likert scale with one being a very negative relationship and seven being a very positive relationship ($M = 5.82$, $SD = 1.17$). The participants reported currently taking an average of three prescription medications ($M = 2.45$, $SD = 1.81$).

Procedure and Data Collection

Participants were from a community-dwelling retirement community in Mesa, Arizona. The participants were recruited through word-of-mouth that began at a weekly dance. Participants themselves contributed to further recruitment by initiating a spontaneous “snowball” method.

Semi-structured interviews were conducted with the individuals who volunteered for participation. The interviews were conducted face-to-face in their homes to ensure

confidentiality, and only one interview was conducted with each participant. The interviews were audio-recorded for transcription. Prior to the interview, the participants received an informed consent letter and completed a demographic questionnaire. After the transcriptions were completed, each participant was contacted to review their own transcript for accuracy and no corrections were noted.

There was not a predetermined sample size for this study as that tradition does not fit with qualitative methods. Instead, interviews were conducted until the data set was saturated. Saturation occurs when additional participants do not contribute additional themes to the data. A peer reviewer was utilized to assist in determining when saturation was met. Small sample sizes are often the norm for IPA studies as the analysis of large data sets may result in the loss of potentially subtle inflections of meaning (Brocki & Wearden, 2006). Further, there seems to be some convergence in clinical and health psychology that six to eight is an appropriate number for an IPA study (Smith & Eatough, 2006).

Establishing Trustworthiness

Methodological rigor of the present study was attained through the application of trustworthiness, which is the extent to which we can trust the results and conclusions of a particular study (Creswell, 2007). There are numerous strategies that qualitative researchers implement to establish trustworthiness; Creswell (2007) suggests employing at least two strategies for maximum trustworthiness. The following three strategies were utilized in the current study.

Peer examination. The first method employed to build trustworthiness was peer examination. The research process and findings were discussed with other researchers who are trained in qualitative research methods (Sandelowski & Barroso, 2003). Specific coding results

and strategies as well as assessment for saturation were determined throughout the process with other researchers. Disagreements between peers were reconciled through a process of repetitive consensus building (Devers & Frankel, 2001).

Researcher's journal. The reflexivity technique, the second strategy, was used to assess the influence of the researcher's background, perceptions, and interests on the research topic. Reflection was used by the researcher keeping a journal in which decisions were recorded regarding methods and their rationale, as well as a personal diary reflecting the researcher's thoughts, ideas, hypotheses, questions, problems, and frustrations. This method was intended to minimize the effects of biases by being open and aware of personal feelings in order to address them, and ultimately to prevent them from influencing the subjective experiences reported by the participants (Creswell, 2007).

Member-checking. The third method, member-checking, is described as "the most critical technique for establishing credibility," (Lincoln & Guba, 1985, p. 314). In member-checking the researcher brings the transcripts, findings, and interpretations back to the participants to solicit their views of the study's credibility (Creswell, 2007). For the current study, the participants were asked to review the transcripts of their interviews. The transcripts were mailed to the participants. All participants were satisfied and no revisions were added.

Chapter 3: Analyses

Interpretative Phenomenological Analysis (IPA) was utilized for the present study. IPA is divided into multiple stages (Smith, Flowers, & Larkin, 2009).

Stage 1. The first stage involved reading and re-reading the text obtained from the semi-structured interviews. The goal was to immerse oneself in the original data to ensure that the participant was the focus of the analysis (Smith et al., 2009).

Stage 2. At this stage, wide-ranging and unfocused notes that reflected the initial thoughts and observations were produced that highlighted initial thoughts and observations, including associations, questions, summary statements, etc. (Smith et al., 2009). Notes produced at this stage constitute the most open form of annotation.

Stage 3. The third stage of analysis involved identifying and labeling themes that characterized each section of the text and called upon psychological concepts and abstractions (Smith et al., 2009). The themes attempted to capture something about the essential quality of what was represented by the text.

Stage 4. This stage involved an attempt to introduce structure into the analysis. The goal was to further refine the data by establishing connections between preliminary themes and clustering them appropriately on the basis of shared meanings, references, or hierarchical relationships (Smith & Eatough, 2006). These connections were then made into clusters.

Stage 5. The fifth stage involved looking for patterns across cases. It helped to take the analysis to a more theoretical level as themes which were particular to an individual case were also representative of higher order concepts which the cases shared (Smith et al., 2009).

Chapter 4: Results

The analysis detailed two major themes associated with older adult alcohol communication with their physician. In the first theme, participants described the factors that hinder alcohol communication. In the second, participants reported that a positive patient-doctor relationship can promote comfort with most conversations and factors that help to create a strong patient-doctor relationship were identified.

Factors that Hinder Alcohol Conversations

The participants revealed that very few had conversations with their physicians regarding their alcohol use, as eight of the participants denied any communication with their physician. Of the three participants that reported having some dialogue with their physician, one described a conversation following the development of an allergy to alcohol. A second participant described having a conversation about alcohol during initial appointments with their physician, but fewer later on. Only one participant indicated having consistent conversations with their physician about their alcohol use. Despite the lack of conversations about alcohol with their physicians, many participants verbalized an understanding of the importance of having these conversations with their physicians. As Bob stated:

In terms of talking to physicians [about alcohol], I don't know if people would have a lot of trouble talking about that really. People that drink excessively I think might lie about it, but it does not do any good. If you go to the doctor, how's he going to doctor you if he don't know what is wrong, you know?

There were multiple sub-themes that illustrated what appeared to hinder older adults from initiating alcohol communication with their physicians. These are described below.

Lack of alcohol problem. Many participants stated that they had not initiated conversations with their physician because their alcohol use was not problematic. They

demonstrated an overall assumption that conversations with their physician were not necessary unless their drinking appeared to be a problem. John expressed this sentiment:

Heck no! I don't have conversations with my physician about alcohol use. I don't drink that much. My mother told me to stay away from taverns because it looks better for you.

To many, it was inconceivable as to why they would have a conversation without an identified alcohol problem. Dottie shared her thoughts regarding this:

Oh, I haven't had any conversations with my physician about alcohol because it is not a problem. I don't talk to my physician about alcohol because I don't think I have a problem or I don't need to. I can't see any reason to bring it up.

Further, many expressed that they would feel comfortable discussing their alcohol use with their physician because their drinking is not problematic. Participants noted they would be honest and forthcoming with their physician because no drinking problem existed. This was expressed by Roy:

It wouldn't bother me at all to discuss alcohol because I do not feel like I overdo it. I don't get to the stage where I'm afraid to get in the car or anything. I am very comfortable with my drinking.

Don also had similar thoughts:

It is not a big deal to talk to my doctor about alcohol. I am not an alcoholic. I am not trying to hide something you know, but if you are my doctor, you ought to know that I do occasionally have a drink.

Overall, the belief that the participants felt they did not use alcohol to excess with their physician kept them from initiating conversations with their physician about their alcohol use.

Alcohol not main focus during appointment. A second sub-theme associated with components of alcohol communication revolved around the idea that alcohol was not a topic of priority with their physician. Many expressed that there were other health concerns that appear to be more important and warrant more time and attention. Mona noted:

We don't talk about my drinking. We discuss cancer and heart troubles. That is the two main things we focus on.

Participants expressed that they do not often think to discuss alcohol use due to other topics identified as more important. Thus, alcohol did not present itself to these older adults as a necessary topic to mention to their physician as demonstrated by Roy:

When I talk to my physician, the first thing I think of is I have high blood pressure. That is what I'm usually asking my physician about. I never even thought about alcohol.

Physician disinterest. Another factor that impeded participants from discussing their alcohol use with their primary care physician was the fact that they believed their physician would not be interested in hearing about it. Participants indicated that their physicians would not find their alcohol use as an important topic to discuss. The idea that physicians would be disinterested in talking about older adult alcohol use was described in the following experiences:

I never told my physician about my alcohol use. No. I don't think he would be interested, do you? (John)

What keeps me from bringing up alcohol use with my physician is I just think that it is probably not important to him. (Mona)

Participants were dissuaded from discussing their alcohol use with their physician because they thought that physicians would not want that information during their appointments.

Office Form Dissuades Conversation. Many of the participants stated addressing alcohol use with their physician was not necessary because they provided the information on the initial intake form. Thus, they believed their physician was aware of any information about their alcohol use and thus superfluous to bring it up again. Many of the participants equated writing information about their alcohol use on the intake form as having a conversation about alcohol with their physician. Betty shared:

Yes I let my physician know. I guess I filled out that one form when I first started going to him, and my habits have not changed and will not change, and I think he realizes that.

There was the sense that physicians did not need to initiate the topic because of the initial intake form. It was assumed that physicians had access to this information and therefore it did not need to be reviewed.

See anytime you see a new doctor, you have to fill out this big long form in triplicate and quadruplicate and they ask you everything on there. When the doctor sees you, which has already been transcribed in many cases, and he looks at that form, and he knows how much you are drinking. He don't even have to ask you. (Don)

I filled out the papers when I went to this doctor in the first place. I have had him for over 20 years. Do you drink...yes. How much...I said one drink per day, and if I go out it is a couple. Not much after that. (Pat)

However, even several participants identified the problematic nature, due to possible changes in alcohol or health that can occur during the course of one's relationship with their physician. For example, Pat described a time in her life when her alcohol use changed.

I believe that when I became a widow, I could have become an alcoholic very easily at that point in my life. [My husband] and I never drank, only when somebody came and we would have a couple drinks. At 53 when I became a widow for the first time, I had a girlfriend who I know was an alcoholic, and I found myself kind of not drinking as much as she did, but I was drinking with her, and all of a sudden it dawned on me that I can't do that. If were to keep going on that road, I could see it getting worse.

Pat's use of alcohol clearly changed from what she had initially disclosed on the intake form during her first appointment with her physician 20 years earlier; however, when asked about conversations with her physician, she merely referred to the information she provided on the intake form.

Past experience with alcohol. Individuals that participated in the study had varying personal experiences with alcohol, all of which contributed to their comfort or discomfort in initiating conversations with their physicians. For example, Dottie shared a story of living with her alcoholic husband:

Now when I had an alcoholic husband, I would go to the doctor and talk to him about it, but it didn't do any good. I would even ask him to give my husband a liver test, but he said it wouldn't do any good. 'If he is going to drink, he is going to drink regardless of what his liver shows.' I would beg. I would go to the physician without my husband and try to get him to talk to him or to take a liver test to know if he had cirrhosis of the liver, maybe he would straighten up. He never did. Plus having an alcoholic husband, you have to drink to live with them, so I was really worried about me at one time when I was younger, as I thought I don't want to be an alcoholic just like he is if I drink so much. I didn't talk to my physician about that because it wouldn't have done any good.

This past experience led Dottie to believe that her physician would not be helpful to her regarding alcohol use, and therefore limited the possibility that she would initiate future discussions with her physician regarding her own use. Phyllis also discussed her previous experiences with alcohol and how that formed her view of alcohol as well as her comfort discussing it with her physician.

My parents both drank, so I have this little thing. It's like if two days in a row go by, and I think 'gee, I would like a drink,' that's okay, I'll do that. But in the next two days, I think 'oh I want another drink,' I probably won't. If I go to a party, I'll probably drink one drink and sip on it the whole party, only because they weren't mean drunks. They were happy little drunks. It scared my brother and I both so neither one of us drink too much because of that. So there really isn't any reason to talk to my physician about it. I'm really careful.

For Phyllis, her experience with her parent's alcohol use created a fear surrounding her own use, leading her to closely self-monitor. As a result, she was comfortable with her use and did not perceive any reason why she should share her use with her physician; she believed she was able to independently keep her alcohol use "under control."

Other attitudes towards alcohol expressed by the participants in the study revolved around their own personal experiences with alcohol. Participants who felt that fears of their own problematic use might also refrain from initiating conversations with their physician. This was the case with Pat:

Knowing that you don't have a problem makes it a little bit easier to talk to your doctor. I believe that when I became a widow, I could have become an alcoholic very easily at that

point in my life. I was 53 when I became a widow for the first time. We never drank when he was alive. After he died, I had a girlfriend, now I know she was an alcoholic, and I found myself not drinking as much as she did, but I was drinking with her, and all of a sudden it dawned on me that I can't do that. If I were to keep going on that road, I could see it getting worse. I never talked about that with my doctor.

Overall, individual's personal experiences with alcohol often dictated whether or not it was necessary to initiate conversation with their physician.

Characteristics that Promote Positive Patient-Doctor Relationships

Participants discussed a variety of physician characteristics that contributed to a positive patient-doctor relationship. It was this positive relationship that was credited for creating a comfortable environment promoting the discussion of most topics. The participants indicated that most topics were easy to discuss with their physician. Topics that were viewed as more uncomfortable included personal and private issues, such as sexual practices. Alcohol was viewed as being an easy topic to discuss with physicians if a positive relationship existed with their physician. A number of characteristics were identified that facilitated a positive relationship. Therefore, communication with physicians regarding alcohol appeared to be enhanced by a number of physician characteristics, including perception of adequate time, knowledge, longevity with physician, age of physician, and physician-initiated discussions.

Perception of adequate time. One of the most widely discussed characteristics that contributed to a positive patient-doctor relationship was the amount of time physicians spent with the patient. Older adults did not want to feel rushed, and wanted to have adequate time to discuss their concerns with their physician. Many recognized that physicians had limited time, but did not want their physician to make them feel hurried. Therefore, even if the physician was rushed, participants wanted the perception that their physician had ample time to discuss all necessary topics. These sentiments were shared by Roy when he said, *"It is easy to talk to my*

physician because he is in no hurry. He does not make me feel rushed.” Participants often stated lack of time as one of the largest deterrents to building a strong relationship. Bob expressed his frustration with this, *“It would be nice if they would stay in there long enough to say something to you.”* Bob shared similar sentiments:

If physicians want to make their patients feel comfortable they should take the time to listen to them. I have gone to doctors that are very business-like. They want you in and out. Good doctors, but you were not seeing them socially, you were seeing them professionally. ‘Tell me what’s wrong and I’ll tell you what we can do about it and you can get out of here and I’ll see the next patient.’ This may or may not tend to give the patient the idea that they really don’t want to listen to them.

Overall, the amount of time physicians spend with their patients was referred to as an important factor in creating a positive patient-doctor relationship.

Humor. Another quality that appeared to enhance the patient-doctor relationship was humor. Participants valued the ability to “kid” with their physician and to make light of serious situations. Humor appeared to make physicians more approachable and helped to ease participants’ comfort with their physician. Participants shared that humor assisted in discussing potentially uncomfortable topics, including personal or private topics.

This was echoed by Betty, *“He has a nice way about him that makes you feel so comfortable, with his good sense of humor.”* Pat stated:

I would sometimes say to him, ‘I am going to go home and have a drink,’ and we laugh about it. He jokes around with me. I feel very comfortable around him and he likes football. In fact, I brought him home a cheese head one year.

Humor appeared to help strengthen the bond between patient and physician and created a safe place for most conversations.

Knowledgeable. Participants appreciated the knowledge that physicians could provide regarding related health topics. The information offered by physicians appeared to strengthen the trust an older adult had in the relationship with the physician. Participants viewed this as

necessary to forming a strong patient-doctor bond, as well as creating a comfortable environment. Bob shared, “*My relationship with my doctor is very good because he is very thorough. He is patient and takes his time with you. He is very knowledgeable.*” Participants also valued the education physicians completed and trusted their credentials. This was expressed by Don:

Well you know he is a professional doctor; I have to assume that he knows what he is doing. Besides that, he is nearly my age. He must know what he is doing, so you know, you have to trust your doctor.

Honesty was also valued. Participants appreciated when physicians were honest about their health, regardless of the outcome, as demonstrated by Betty:

Like I discussed with him the other day for example, ‘Do you think I will ever get back to where I used to be?’ He is very open in his comments, and he said, ‘Probably not.’ I like a physician that will look you in the eye and continue the conversation with you after he makes such a remark, but he is honest and seems concerned about what is going on with me. That makes me feel very comfortable.

An additional value held by participants was the idea that physicians would use their knowledge to tailor their treatment to the individual patient. The older adults wanted choices regarding their treatment, including medications. It strengthened the bond when physicians were able to offer treatment that appeared to be uniquely tailored to the individual’s needs and values. Joyce stated:

He is very up on the idea of making me healthy. I don’t like taking a lot of medicine and he is not a pill pusher. He is not one that just wants to prescribe for you all the time. He gives me choices of what I could take. Gives me organic options.

Joyce’s relationship with her physician has been strengthened as she noted her physician’s attempt to find solutions that she was comfortable with. Mona stated that she preferred when her physician offered her several choices and provided her with more information about the health topic. She identified it as a quality that would strengthen their relationship.

I would like my physician to explain a little bit more about the problem and maybe have a choice of one or another medicine if I need it.

Phyllis offered a story in which a physician offered support during a time when she needed help the most.

Well our son died. He was only 52. So I called my old physician from Montana because we were up there for the funeral. I was devastated. I said I need something to help me get through the funeral and all this stuff, and she said I don't prescribe for that. I quit her right then and there. I needed something to sleep. I couldn't sleep. So I just quit her and I went to my husband's doctor. His doctor had never seen me, but I called and explained the circumstances, and he called in a prescription so...that was it. I have just stayed with him because he was taking me as a person and the other wasn't. It was her idea of how to treat things, but I'm sorry. I never went to the doctor. If I was asking for something, it was because I really needed it.

Phyllis not only valued her physician's knowledge, but also using it during a time of need.

Phyllis was able to develop a sense of trust and respect because her physician was able to help her when she felt she could not cope on her own. This was thought to be an important quality in building a strong patient-doctor relationship.

Overall, participants valued the knowledge physicians provided regarding their health. They also valued when a physician was honest about health outcomes and tailored treatment to the individual. All these qualities helped to increase trust, thus building a strong relationship.

Longevity. Participants referred to the number of years they had spent with their physician as a positive factor for building the patient-doctor relationship. From participants' perspective, longevity allowed the physician to better understand the patient, and participants thought physicians were more effective when they were able to know their baseline level of health. Longevity with one's physician was also helpful for the patient to feel comfortable with the physician. This was illustrated by Pat:

I have had him for so many years, that it is like seeing an old friend when I go see him. We can kid with each other. I trust him completely. He's got me through cancer twice, so I really trust him.

Bob echoed Pat's sentiment that his relationship has improved due the amount of time they have spent together.

You have to get to know your patients and that is the benefit of going to the same doctor year after year. You get to know each other. If I can go in now with a pain that I have not had in the last five years, well this might raise a red flag with him.

Age of Physician. Several older adults referred to their physician's age as contributing to a stronger bond between the two parties. In particular, participants appeared to appreciate if their physician was older. They felt that their physician would better understand their own health concerns and also share similar values. Joyce stated:

He is an old Irishman, and he is probably 62 or 65, I don't know how old he is. He has gray hair like us. He is so down to earth and it is easy to talk about my problems and concerns with him.

Physician-initiated preference. There was an overwhelming consensus that although participants were not likely to initiate conversations about alcohol with their physician, it would be a welcomed topic during their primary care appointment, particularly if it was initiated by their physician. Many expressed that they would be comfortable and would not feel judged, as demonstrated by Betty:

If my doctor brought it up I wouldn't be worried that he thought I had a problem. I would think that he was only monitoring my health. This is how I see it. Because if you don't have a problem, you wouldn't be thinking he thinks I have a problem.

When asked what physicians could do to help older adults be more comfortable discussing their alcohol use, Dottie responded:

They could bring it up themselves. They could say, how much do you drink? Do you think your drinking is a problem? Do you drink at all? Bring it out.

This appeared to be the case for a majority of the participants, as they recommended the best way for physicians to discuss an older adult's alcohol use was to initiate the conversation. Participants

also felt that they would be more comfortable asking important questions regarding their alcohol use once the topic had been initiated. For example, Mona shared:

If he were to ask me about it, I would ask him if he thought my alcohol use was a problem and does it interfere with my medicine.

Both appeared to be necessary and important questions, yet would not be asked unless first initiated by the physician. Therefore, physician-initiated alcohol discussions appeared to be extremely important not only for the physician's knowledge, but the patient's overall health as well.

Chapter 5: Discussion

The purpose of interpretive phenomenological research is not to answer specific questions, but to distill the essence of the phenomenon from the participants' narratives. The current study provided some answers to the research questions, and as is often the case with emergent qualitative methods, answered some unasked questions.

Of note, few participants in the study had conversations with their physician regarding alcohol. Of the eleven participants interviewed, eight reported never having a conversation with their physician about alcohol use. This is consistent with the literature. For example, Larsson, Saljo, and Aronsson (1987) studied patient-doctor communication and found that drinking habits were addressed in only 30% of the cases. In a study about physician alcohol screening practices, Sharp and Vacha-Haase (2010) noted physician alcohol screening practices and indicated that physicians reported screening 73% of their new patients upon intake and only 44% of their existing patients. Despite the lack of conversations about alcohol, research has suggested that conversations and brief alcohol counseling during primary care appointments reduce alcohol consumption, adverse health consequences, and health care utilization in patients who drink above recommended limits (Bertholet, Daeppen, Wielishbach et al., 2005; McCormick, Cochran, Back et al., 2006; Moyer, Finney, Wearingen et al., 2002). Regardless of the positive health benefits, patient-doctor conversations about alcohol use remain sparse due to the topic's sensitive nature. Patient-provider interactions around other sensitive issues have been examined with similar results to those reported here. Epstein et al (1998) analyzed videotaped discussions of HIV during primary care visits. They found that each encounter contained "awkward moments" and providers frequently avoided discussions of HIV risk. Another study which examined interactions between drug-using patients and physicians, found that providers avoided addressing

patients' pain and addiction-related issues, and demonstrated discomfort during these interactions (Merrill, Rhodes, Deyo et al., 2002). Finally, Meredith and Marzel (2000) found that providers lacked the skills needed to effectively assess and manage patients with depression.

Research Questions

Older Adult Comfort Discussing Alcohol. Overall, participants reported that alcohol would be a comfortable topic to discuss with their physician. Although they were not likely to initiate the conversation, many indicated that it would be a comfortable topic if physician initiated. These results contrast with previous research which found that older adults have increased emotional discomfort when visiting doctors due to concerns such as maintaining health and functional abilities (Gastel, 1994). Lipkin et al. (1995) found that patients could be anxious or embarrassed about concerns such as alcohol use. Further, Peters et al. (2008) found that patients believed that discussing psychosocial factors was uncomfortable for both themselves and their physician, causing them to avoid disclosing this information.

Not only did participants in the current study state that they would be comfortable discussing alcohol use with their physician, they indicated that they could be honest about their current use. One of the major barriers for physicians when having alcohol-related conversations is the potential for patients to be less than honest in disclosing their drinking practices (McCormick et al., 2006). Every participant in the current study believed they could be honest with their physician.

McCormick et al. (2006) found that patients often disclosed honest information regarding their alcohol use, but providers did not explore the disclosures. Specifically, patients disclosed high levels of consumption and negative health consequences and providers often failed to pursue the disclosures (McCormick et al., 2006). Finally, although participants appeared to be

comfortable, discomfort on the part of the provider has been evident during alcohol-related discussions (McCormick, 2006). The discomfort included hesitation, stuttering, inappropriate laughter, and ambiguous statements. These behaviors were not observed or were less apparent when alcohol was not being discussed.

Factors that hinder communication. Physicians have identified biases or barriers that prevent them from having conversations about alcohol use with their patients (McCormick et al., 2006; Peters et al., 2008). The current study revealed that older adults also have biases that hindered or prevented them from initiating alcohol communication with their physician. First, many participants had not had conversations with their physician because they believed that their alcohol use was not problematic, thus not warranting conversation. This has been supported in the literature, as Lipkin et al. (1995) revealed one barrier to patients voicing concerns with their physicians was the perceived non-seriousness of the topic. Patients were less likely to initiate conversations with topics that were viewed to be relatively non-serious.

Another barrier reported by participants in the current study was the feeling that alcohol was not a topic of priority. They believed that there were many other health topics that were more important to discuss with their physician, such as cancer, high blood pressure, and heart disease. Previous research suggests that patients often have more than one concern when they visit their primary-care physician, including medical problems and requests for information (Robinson, 2001). Even if patients had a single concern, it was often multifaceted, containing multiple biomedical and psychosocial components. Physicians' knowledge of the full spectrum of patients' concerns was vital not only to the accurate diagnosis and treatment of medical conditions, but to the delivery of comprehensive and quality health care (Robinson, 2001). However, research suggests that additional concerns beyond the "main one" were difficult to

address and often were not addressed (Robinson, 2001, p. 640). Research has also shown that patients often simplify their problems or focus on one element to fit in with their expectation of the consultation and the capacity of the physician to help (Peters et al., 2008). Each of these factors contributed to lack of alcohol conversations between patients and physicians.

A third barrier to initiating conversations about alcohol was the feeling that participants had already provided the information on the initial intake form. To the participants, writing about their alcohol use on the form constituted a conversation and thus it was not necessary to revisit. Research has not addressed this topic area.

Finally, individuals' past experience with alcohol often served as a barrier to alcohol communication with physicians. A family history of alcohol caused some participants to be more conscious of their alcohol use, and thus, deemed unnecessary to discuss with their physician. The lack of communication with their physicians due to past experiences would seem problematic due to the documented familial link of alcohol addiction, as the familial transmission of alcohol has been well established and consistently supported (e.g., Dinwiddie & Cloninger, 1991). The heritability of alcohol abuse has been estimated to be as great as .98 for males and as low as .10 for females (Caldwell & Gottesman, 1991). Twin studies consistently show higher concordance for alcohol abuse in MZ twins than DZ (Caldwell & Gottesman, 1991). Therefore, individuals with a family history of alcohol use should be having regular conversations with their physicians about their alcohol use. Essentially, past experiences with alcohol use served as a deterrent to communication about alcohol use despite the common familial link.

Factors that facilitate alcohol communication. Participants revealed multiple physician factors that strengthen the patient-doctor relationship, allowing for increased comfort in discussing topics such as alcohol. The characteristic that most often contributed to a positive

patient-doctor relationship was the amount of quality time they had with their physician. Participants wanted the opportunity to feel heard without the perception of being rushed. Although participants recognized physicians had limited time, they wanted to feel that their treatment was not impacted. Similarly, participants revealed that the biggest deterrent to building a strong patient-doctor relationship was inadequate time and feeling rushed. Similar results were obtained by Greene and Adelman (1996), who discovered that older adults recognized that in today's managed care climate, physicians have less time to spend with patients and therefore more likely to limit their number of questions. Peters et al. (2008) found that most patients were keenly aware of the limited time available in consultations with their physician. This resulted in a struggle to convey the complexity of their illness, and frustration that their physician could not appreciate the full picture of their problems and the various avenues that had been pursued to treat them. Physicians have also listed lack of time as a barrier to having alcohol-related discussions (Beich, Gannik, & Malterud, 2002). Although most physicians acknowledge that addressing alcohol misuse is an important clinical responsibility, many report that they do not have adequate time to address it with patients (McCormick et al., 2006).

Other physician characteristics were reported as helping to create a strong patient-doctor relationship. One of these factors included a sense of humor, which made physicians appear more approachable and assisted individuals in feeling comfortable to discuss potentially uncomfortable topics. Participants also believed a physician's knowledge regarding health and the ability to tailor treatment for each patient was an important quality. The length of time with a physician led to feelings of comfort and trust and proved to be important for building a strong relationship. Lastly, an age similar to the older adult population seemed to contribute to a stronger bond, as participants felt that their physician would better understand their health

concerns and share similar values. Previous research has also identified various characteristics of the physician that can influence communication. These have included demographics, training, confidence in treatment skills, and attitudes towards treatment health problems (Brown & Wissow, 2009). These characteristics support the importance of a physicians' knowledge. Similarly, Brown and Wissow (2009) identified characteristics of the patient that influence communication, which included demographics, health status, experience with health services, familiarity with the physician, and confidence that the physician is a confidential source of care.

Finally, participants agreed that they are unlikely to initiate conversations about alcohol with their physician. Research has showed similar results for breast cancer research in which some older women believed that not questioning their physician was necessary for good healthcare (Adler et al., 1998). Asking too many questions was perceived as potentially antagonistic to physicians, which might lead them to provide the patient with poor care. Despite the participants' hesitation with initiating the topic, it was unanimously agreed that it would be a welcomed topic if initiated by their physician. Participants thought that this would be the best way for alcohol to be discussed during an appointment. In addition, participants believed that they would feel comfortable discussing the topic if initiated by their physician and would not feel judged. This countered a popular bias by physicians who thought that initiating alcohol conversations with older adults could harm the patient-provider relationship (Aborelius & Thakker, 1995; Beich, Gannik, & Malterud, 2002).

Implications

The present study suggests numerous implications for both older adults and physicians. Implications for older adults include increased quality health care and agency in making health care decisions. Implications for physicians include increased insight regarding how older adults

view their interactions regarding alcohol use and improved education. Overall, increased older adult patient-doctor alcohol communication would be the main goal.

Implications for older adults. The most important implication the current study provides is increased quality health care for older adults. Becoming aware of the barriers that prevent older adults from initiating alcohol conversations with their primary care physicians will help to more thoroughly explain the overall deficit in older adult patient-doctor alcohol communication. Thus far, research has primarily focused on physician factors that influence alcohol communication including attitudes (Arborelius & Thakker, 1995; Sharp & Vacha-Haase, 2010), biases (Sorocco & Ferrell, 2006), and diagnostic difficulties (Sattar, Petty, & Burke, 2003). However, conversations are two-sided and information regarding barriers from both parties is necessary to truly understand the phenomenon. The current study begins to answer some of these questions and increased knowledge regarding older adult barriers to communication should lead to overall increased alcohol communication between older adults and their physicians.

There are multiple benefits to increased alcohol communication for older adult patients. Primary care physicians can have a major role in the care of patients who use alcohol (O’Conner & Schottenfeld, 1998). Specific health benefits include effective screening and assessment for problematic drinking, patient education regarding possible negative effects of alcohol use, and office-based interventions and referral to specific services if indicated (O’Conner & Schottenfeld, 1998). Information regarding alcohol is also necessary when prescribing medications in order to avoid potential interactions (Moore et al., 2007).

Most importantly, older adults would be well informed regarding their health and can thus make decisions that are most appropriate for them regarding alcohol use. Research suggests that although alcohol communication between patient and doctor is extremely important, it is less

important than the psychological readiness of the patient (Davis, 1968). Therefore, providing information to the patient allows them to have the necessary information when making important decisions about their life and their health.

Implications for Physicians. The current study supports the increased need of physician education regarding alcohol communication. Physicians could benefit from education on the barriers that prevent older adult patients from initiating alcohol conversations. These include the belief that the physician would not be interested in alcohol information, that their alcohol use was not a problem, the fact that the information had previously been provided on the initial intake form, and past experience with alcohol. Physicians could also improve patient care by being aware that older adults in the current study were comfortable discussing the topic of alcohol, in contrast to the popular belief that older adults would be offended and initiating the topic could damage the relationship (Aborelius & Thakker, 1995; Beich, Gannik, & Malterud, 2002). Finally, it is important to provide education regarding the older adult preference that alcohol communication be initiated by physicians during the medical appointment.

Research has supported the increase of quality alcohol education for physicians. McCormick et al. (2006) reported that providers presented skepticism about the effectiveness of alcohol counseling and inadequate training as barriers to having alcohol communications. Further, physicians who had more positive perceptions of their alcohol management skills, including perceived skill in the ability to diagnose and treat alcohol related problems, were more likely to screen their older adult patients for alcohol (Sharp & Vacha-Haase, 2010). Johnson et al. (2005) found that primary care physicians perceived themselves as being less prepared to diagnose substance abuse than other chronic conditions, and that physicians held the attitude that their substance abuse treatment options are “generally ineffective” (p. 1079). Moreover,

Duszynski, et al.(1995) reported that only 15% of physicians believed they were doing all they could when working with their patients' alcohol problems.

Providing physicians with relevant skills and knowledge in alcohol management would likely help to increase their confidence and motivation to initiate alcohol-related conversations. Research has shown significant correlations between education, most notably continuing medical education and confidence levels (Duszynski, et al., 1995). With regard to education, skills-oriented approaches have shown to be effective teaching methods when it comes to the delivery of prevention services with adolescents and could be used with older adults as well (Marcell, et al., 2002).

There is a growing body of evidence to suggest that physician intervention among patients with either a potential for a drinking problem or an already established drinking problems is effective (Durand, 1994). Specifically, these results have been found in emergency room patients. Physicians who asked their emergency room patients about their alcohol use and briefly provided information about how to reduce harmful drinking patterns found lower rates of risky drinking at a three-month follow-up compared to patients who were not given written information about reducing their drinking (SAMHSA, 1998). The brief intervention took less than ten minutes to complete, but demonstrated significant results in the reduction of risky drinking behaviors. Evidence suggests that positive treatment outcomes are found with older adult patients as well. In particular, long term abstinence and recovery for older adults is matched or superior to that for younger adults (Atkinson, 1990). Additionally, there is evidence that older adults welcome information regarding alcohol use from their physicians, which is similar to results found in the current study (Fink, et al., 2001).

Essentially, physicians are able to make significant changes in an older adult's well-being by addressing problematic drinking. In particular, older adult patients have shown improvements in physical and mental condition following screening and brief intervention techniques by primary care physicians (Tabisz et al., 1993). Physicians need to feel comfortable talking to their older adult patients about their alcohol use, due to the significant improvements patients make following brief intervention.

Limitations and Future Directions

There are several important limitations to this study. First, participants were older adults living in a similar location and of similar health status. These findings may not extend to other settings. Looking at community dwelling older adult communications from other regions might also provide valuable information.

Second, the current study used patient self-report for its data, relying on the individual's memory. The current study would benefit from performing qualitative research by recording older adult patient-doctor interactions to determine the extent of alcohol communication. For example, McCormick et al. (2006) analyzed audio taped patient-provider interactions regarding smoking and alcohol. A similar study using older adult patients could be extremely beneficial, providing information about the actual interactions.

Significant research is needed regarding older adult patient-doctor alcohol communication. Little research focuses on communication with older adults, and thus warrants more attention. Research also needs to continue to focus on the physician barriers as well as the older adult barriers that may be contributing to the lack of alcohol communications during primary care appointments. The current study laid the ground work for patient barriers that may

contribute; however, much more needs to be done. Identifying more specifically how these barriers influence alcohol communication would be important.

Research is needed regarding how information provided on an initial intake form influences patient-doctor communication. For example, looking at how information provided on the intake form impacts communication between physicians and older adult patients, including what they choose to share during appointments.

Conclusion

The present qualitative study suggested that alcohol communication does not often occur in patient-doctor interactions. Older adult participants revealed several biases that dissuade them from initiating the topic with their physician, including perceived lack of problem, physician disinterest, completing the information on the form and past experience with alcohol. However, participants stated that they would feel comfortable discussing the topic if initiated by their physician, and identified several physician characteristics that would improve the patient-doctor relationship, including humor, longevity, perceived adequate time, knowledgeable, and similarly aged. This information could greatly improve the frequency and quality of patient-doctor communication during primary care appointments, thus leading to more effective healthcare practices.

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