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PHYSICIANS' PERCEPTIONS OF ELDERLY ALCOHOL ABUSE

by

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(Specialty in Gerontology)

A thesis

submitted in partial fulfillment

of the requirements for the degree of

Master of Arts

Lakehead University

March 1998

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ABSTRACT

Alcohol abuse is often hidden and unrecognized problem among seniors. Although the degree of the aged affected by alcohol abuse may not be extremely high, alcohol consumption appears to be particularly toxic in the elderly, claiming a very high medical and social toll. For a large number of elderly, primary care physicians are the most accessible professionals who can diagnose and treat their drinking problems. However, research indicates that physicians are not assuming the role of diagnosing, referring or treating elderly alcohol abusers with any regularity, effectiveness or enthusiasm. This study examines the issue of under-diagnosing of elderly alcohol abuse by primary care physicians, and, specifically, seeks to answer the question: what are the causes for the low recognition and treatment rate of elderly alcohol abuse by primary care physicians?

Twenty-eight primary care physicians practicing in Thunder Bay, Ontario, were questioned regarding their perceptions of elderly alcohol abuse. Attention was given to physicians' subjective assessment of the prevalence, identification and treatment rate of elderly alcohol abuse in their own practices. An important part of the study was the examination of physicians' self-perceived attitudes toward elderly alcohol abuse. The results indicate that the cause for the low recognition and treatment rate of elderly alcohol abuse by primary care physicians is multifactorial, with many of the factors being interrelated. The identified factors are: lack of training on alcohol abuse in medical schools, low attendance at continuing medical education seminars on alcohol abuse, negative attitudes toward elderly alcohol abuse, lack of time/large patient load, and existing treatment programs perceived as non-effective.

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Chapter One

INTRODUCTION AND PROBLEM STATEMENT

Alcohol abuse among the elderly is a problem that often remains hidden and unidentified. Until the 1970s, there was little research done on alcoholism among the elderly. Social researchers' interests in gerontology were low, and alcoholism was not perceived to be a problem of the aged (Adams, Magruder-Habib, Trued & Broome, 1992; Carstensen, Rychtarik & Prue, 1985; Cohen, 1988; Lichtenberg, Gibbons, Nanna & Blumenthal, 1993). Considerable evidence has been accumulated in recent years, however, which suggests that the old as well as the young abuse alcohol in significant numbers, and problem drinking in old age is a situation that should not be neglected.

Demographic information suggests that the problems of alcohol abuse among the elderly will increase at least in proportion to the population growth of that sector. Statistics Canada (1991) reports that the proportion aged 65 and over increased to 3.2 million in 1991, which is 11.6 percent of the total population. Canada's population continues to age, and the elderly will number nearly four million people by the turn of the century (Stone & Fletcher, 1986). Demographic projection shows that by the year 2036, the number of seniors will increase to 8.7 million, or 22 percent of the total population (McKie, 1993).

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Prevalence of alcohol abuse among the elderly reported in the literature is quite varied due to different operational definitions, methods and models used in the studies. The quantity or frequency of drinking is not always relevant because usually there is an increased susceptibility to the effects of alcohol with aging (Garver, 1984). Alcohol abuse can pose a serious problem among the aged since the drug appears to be particularly toxic in the elderly, claiming a very high medical and social toll (Crook & Cohen, 1984). Nevertheless, once an elderly person is diagnosed as a problem drinker, an appropriate treatment can take place.

Studies show no evidence that elderly alcoholics are untreatable, and many report good treatment outcomes (Atkinson, 1987; Blazer & Pennybacker, 1984; Brody, 1985; Philion, 1988), however, older problem drinkers do not utilize alcohol treatment programs in large numbers. Evidence suggests that people aged 65 and over constitute only 2 percent of admissions to alcohol treatment facilities although the elderly form a large proportion of those admitted to hospitals with medical problems stemming from alcohol abuse (Schonfeld, Rohrer, Zima & Spiegel, 1993). Chatham (1984) points to several reasons for the low utilization rate of treatment programs: unawareness of the problem, hiding and denying the drinking problem, refusal to accept treatment, unwillingness of the family to recognize elderly alcohol abuse, and failure to diagnose alcoholism by physicians.

Mignon (1993-94) suggests that the burden of identifying problem drinkers among the aged falls heavily on the shoulders of physicians. For a large number of elderly, physicians are the most accessible professionals who

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can diagnose and treat their drinking problem. Bagley (1997) suggests that few professionals are better suited for this task than family physicians since they are trusted and visited by patients on a regular basis. The Canadian National Population Health Survey from 1994-95 indicates that 89 percent of the elderly consulted a physician at least once in the previous year (Statistics Canada, 1995), and approximately 40 percent of Ontarians aged 65 and over visit their family physician six or more times a year (McIsaac, Goel & Naylor, 1993). The medical profession can further play an important role in discovering and identifying problem drinking since people with alcohol problems are known to use primary health care services more than the rest of the population (Peters et al, 1996). McIntosh and Sanchez-Craig (1984) therefore suggest that a family physician is in a particularly good position to identify problem drinking in its early stages through history-taking or the use of a specific questionnaire.

The physician-patient encounter provides an ideal opportunity to diagnose alcohol abuse (Murray & Fleming, 1996). Medical practitioners, as gatekeepers of the health care system, play a crucial role in determining whether the diagnosis of alcohol abuse is made and whether the patient is offered treatment (Mignon, 1992). Many patients indicate they would like their physicians to recognize and participate in the treatment of their alcohol and drug problems, believing that physician involvement is appropriate (Lewis, Niven, Czechowicz & Trumble, 1987). Physicians themselves agree that primary care practitioners have an important role in early detection and intervention of their patients' alcohol problems (Brewster et al., 1990).

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However, various studies suggest that physicians have not been very successful at diagnosing substance abuse among the elderly (Adams et al., 1992; Kamerow, Pincus & MacDonald, 1986; Lichtenberg et al., 1993; Murray & Fleming, 1996; Willenbring & Spring, 1990). The research shows that medical practitioners are not assuming the role of diagnosing, referring and treating elderly abusers with any regularity, effectiveness or enthusiasm (Coulehan, Zettler-Segal, Block, McClelland & Schulberg, 1987; Curtis, Geller, Stokes, Levine & Moore, 1989; Moore et al., 1989; Philion, 1988).

There are a number of questions which can be raised from these research findings. Why are physicians not diagnosing and/or treating elderly alcoholics? Is there a lack of medical training specific to alcoholism? Is there a tendency to attribute the effects of alcohol to age or dementia? What are the barriers to better identification of alcohol abuse among the elderly? To what degree are physicians interested in addressing older patients' drinking problems? What are their attitudes toward elderly alcohol abuse? Limited research has been done on the above questions. This study focuses on the under-diagnosing of elderly alcohol abuse by primary care physicians, and, specifically, seeks to answer the question: what are the causes for the low recognition and treatment rate of elderly alcohol abuse by primary care physicians?

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Chapter Two

CONCEPTUAL FRAMEWORK

The vast majority of research on alcohol abuse addresses the characteristics of alcoholics and treatment issues. This study removes the focus from those who have an alcohol problem, and places the attention upon physicians, and how they react to drinking problems of their elderly patients.

This thesis is not based on any specific theory, but is rather concerned with the causes for under-diagnosing elderly alcohol abuse, and the practical suggestions that can be derived from the obtained knowledge. However, a conceptual framework was sought which may help to explain the findings gained in this research. The conceptual framework seen most appropriate for this task is professional socialization since it is believed that this viewpoint can explain the causes for low identification and treatment rate of elderly alcohol abuse by primary care physicians. The conceptual framework of the thesis comes from a premise that physicians are professionally socialized to the way they react to elderly alcohol abuse. It is hoped that the findings of this study can be understood and explained by this viewpoint.

Medicine is seen and accepted by society as a profession; moreover, it has often been considered the archetype of professionalism (Baszanger, 1985). A profession is distinct from other occupations since it has been given the right to control its own standards of delivery. It is granted autonomy,

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including the exclusive right to determine who can legitimately do its work and how the work should be done (Freidson, 1970).

Cockerham (1986) believes that two basic characteristics are sociologically relevant in explaining professionalism: prolonged training in a body of specialized knowledge, and an orientation toward providing a service. The professionalization of a specific occupation occurs with emphasis on the importance of knowledge, the founding of a training school which progresses into a university, followed by the development of a local and national association, the passing of licencing laws, and the establishment of a code of ethics (Abbott, 1991). Turner (1995) states that whether an occupation is a profession depends upon the achievement of theoretical knowledge as the basis of a skill, the development of specialized training and education, the testing of the competence of members by formal examinations, the development of a professional organization, the emergence of a professional code, and the development of an altruistic service.

Medicine, with its characteristics, conforms well to these definitions of professionalism. Nancarrow Clarke (1990) states that physicians themselves determine what constitutes appropriate subject matter for the study and practical experience of medical students. Licencing and admittance standards are also determined by the profession, and their own norms are incorporated in the code of ethics. Physicians are mainly controlled by various associations and organizations, such as the College of Physicians and Surgeons, which are comprised primarily of practicing physicians.

Before a person can become a professional, he/she has to be

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socialized into the particular profession. Bucher and Stelling (1977) offer a theory of professional socialization. They believe that professional socialization occurs as a result of the interplay between (1) external structural variables, (2) internal structural variables, and (3) situational or interactional variables.

The major external structural variables are professional communities that exist outside the particular formal organization in which the training program is situated, and larger formal organizations to which the training program is linked. The internal structural variables include professional organization, and the structure of training programs. Professional organization is comprised of a different number and types of professionals, their interrelationships, and the nature of their participation in the organization. Each of these professionals has ties to external professional communities, and is influenced by these ties. The structure of particular training programs is a function of the nature of the professional organization. These internal structural variables determine the nature of the situational or interactional variables present in the training situation. The kinds of professional activities or roles in which trainees engage, the types of models provided, the nature of the peer group, and the nature of coaching all reflect the professional organization and the structure of the training program set up by the professionals in the organization. The trainees' participation in these various activities determines the outcome of professional identity, commitment and career.

The influence of these three variables is not unidirectional. Trainees

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are not simply responding to events around them; they are actively evaluating these events and constructing their own responses to them. Through this interplay a sense of mastery and a reliance on one's own judgement progressively develops. An autonomous professional who has constructed his/her own professional identity emerges. However, the trainee's professional identity, level of commitment, and projected career, strongly reflect the structural and situational variables within the training program (Bucher & Stelling, 1977).

Chappell and Colwill (1981) point to two different models of professional socialization of physicians. The first model focuses on the medical school as the main socializing agent for the profession. The second model argues for the greater relevance of post-graduate experiences, such as the situational factors within the work environment.

The first model claims that individuals are socialized into the professional role during their training since medical school serves as the instrument of professional socialization. Medical education is seen as a process of socialization designed to prepare students to function in the role of physician (Kurtz & Chalfant, 1984). Medical schools do not only teach medical knowledge, but also systematically expose students to professional values and norms. As Merton (1957) states: "The profession of medicine....has its own normative subculture, a body of shared and transmitted ideas, values and standards toward which members of the profession are expected to orient their behaviour. The subculture refers to more than habitual behaviour; its norms codify the values of the profession" (p. 71).

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Medical schools have two functions: communicating to students the cognitive standards of knowledge and skills, and conveying the moral standards of values and norms (Merton, 1957). Students are engaged in the socialization process through which they develop their professional self, with its characteristic values, attitudes, knowledge and skills which govern their behaviours in a variety of professional situations (Merton, Reader & Kendall, 1957).

Kurtz and Chalfant (1984) also believe that a process of socialization occurs during medical education. In addition to the formal learning that constitutes the obvious function of the teaching program, there is a simultaneous informal function taking place. The formal educational program produces individuals who possess the skills necessary for the technical practice of medicine; the informal process of socialization provides medical students with particular attitudes toward themselves, their work, their patients, colleagues and professional organizations.

The strength of professional socialization is rooted in the length and institutional character of training (Larson, 1977). The institutional setting of medical school transmits and advances the culture of medicine (Fredericks & Mundy, 1976). The students are taught values, although not explicitly, along with basic science (Conrad, 1988). The long socialization process which occurs during training is designed not only to build up the required technical competence, but also to firmly establish values and norms of the profession (Rueschemeyer, 1972). Assimilation to the medical culture occurs as students internalize this culture's key values (Baszanger, 1985). When students enter

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medical school, their individual traits are easily identifiable; however, as they proceed through training, their distinguishing traits become blurred, and a commonality emerges. Professional socialization homogenizes students' distinctive individualities (Coombs, 1978).

The second model of professional socialization of physicians questions the role of medical school beyond the learning of technical knowledge and skills, placing greater relevance to work experience. This approach maintains that situational factors within the immediate work environment affect professional's current attitudes (Chappell & Colwill, 1981). Freidson (1970), as a proponent of this approach, argues that education is a less important variable than the work environment. Although the medical profession considers medical education to be the major single factor determining the performance of the practicing professional, Freidson questions the actual accomplishments of medical schools. He agrees that while medical education provides a great deal of technical knowledge and skill to its students, the way physicians apply their skills after graduation reflects the organization of the work environment rather than the academic standards of their teachers (ibid.). The critical elements of professional behaviour, such as ethics, the level of technical competence, or the approach to the patient, do not vary so much with the individual's formal professional training as with the social setting in which he/she works after the formal education. A significant amount of behaviour is situational in character since individuals are constantly responding to pressures of the situations they are in at any particular time (Freidson, 1971).

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More recent authors embrace both models of professional socialization of physicians, and this approach has not been challenged. Olesen (1977) believes that the process of professional socialization begins on campus and extends into the rituals of recruitment and subsequently through 'learning the ropes' on the job. Colombotos (1988) maintains that professional socialization of physicians does not end abruptly with their residency training. Social and organizational context, such as medical schools, residency training programs and practice settings, all shape physicians as professionals. Professional socialization can be seen as multidimensional: both earlier experiences and later-work experiences may influence physicians' attitudes and behaviour (ibid.). In some instances new experiences replace or moderate the influence of earlier experiences; in others, prior experience may integrate the impact of new experiences (Martin, Arnold & Parker, 1988). The perspectives that physicians acquire through professional socialization, either during their medical training or through the work environment, permeate their consciousness, forming a specific lens for viewing the world (Conrad, 1988). It can be hypothesized that how physicians perceive, and subsequently deal with medical issues, including elderly alcohol abuse, stems from their professional socialization.

The literature shows that medical education has provided medical students and residents with limited educational programs, curricula, and learning experiences of how to care for patients with alcohol related problems (Murray & Fleming, 1996). Mainstream medical education has virtually ignored alcohol and other drug abuse as a major concern (Lewis et al., 1987).

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Many medical schools devote less than 1 percent of their teaching hours to an integrated approach to alcoholism and drug abuse, and very few schools require any clinical experience in alcohol and other drug abuse (Kamerow et al., 1986).

The Canadian Medical Association (1993) reports that few medical schools in Canada have core undergraduate courses on alcohol related problems, and relevant training experiences for residents are practically nonexistent. Family medicine training programs report a deficiency of adequately trained faculty serving as role models to medical students and residents (Cotter & Callahan, 1987). A common response to pressure to include substance abuse training in medical schools or post-graduate education is to offer an elective course, with not much exposure to the range of problems and successful treatment intervention of substance abuse (Lewis et al., 1987).

Students entering medical school may share society's stereotype of the alcoholic as a 'skid row' individual with a poor social and medical prognosis (Lewis et al., 1987). The completion of undergraduate medical studies does not guarantee this attitude will change. Limited knowledge and training in alcohol abuse may leave physicians unprepared in their skills and attitudes for diagnosing and treating patients with substance abuse problems (Cotter & Callahan, 1987).

Several authors in their studies (Cotter & Callahan, 1987; Kamerow et al., 1986; Murray & Fleming, 1996) call for increased amount of curriculum time devoted to alcohol abuse teaching, with special attention placed on the

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teaching areas related to diagnosis of alcohol abuse. They also see a need for an increased emphasis on how physicians' attitudes toward alcohol abuse impact their clinical practice. In 1993, Canadian Medical Association published a policy summary on alcohol abuse in which it recommends that all Canadian medical schools establish undergraduate, residency and continuing medical education programs on alcohol-related problems. It also recommends that medical schools organize faculty development programs, clinical teaching units and research programs related to alcohol abuse problems (Canadian Medical Association, 1993). These recommendations show recognition by the national professional organization of the importance of training on alcohol abuse for physicians.

Compounding the problem of limited training on alcohol abuse as an obstacle to identification and treatment is the advanced age of the patient. The literature suggests that physicians may have a negativistic attitude toward the elderly population. Strain (1981) believes that this attitude has its roots in medical training. He maintains that medical education attaches minimal importance to acquiring a basic understanding of the normal aging process. The student's contact with the aged is primarily with those individuals who suffer from severe illness, and aging becomes equated with death, with irreversible disability, and with therapeutic hopelessness and helplessness (Strain, 1981). Biomedicalization of aging may occur, dealing in biomedical terms with an aging population (Estes & Binney, 1989).

Adelman and Cohan Albert (1987), in their critical review of the literature, point out that medical students expressed more negativism toward

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the elderly than any other age group. The authors conclude that ageism may well be an occupational hazard of the medical profession. Because of the nature of their work, physicians interact most often with the elderly who are ill and frail. Hence, they may be more susceptible than the lay public to develop ageist assumptions (Greene, Adelman, Charon & Hoffman, 1986). Limited exposure to positive first-hand experiences with a variety of elderly individuals, and a lack of effective physician role models during professional socialization all contribute to negative attitudes toward the aged (Adelman & Cohan Albert, 1987).

Medical encounters between physicians and older patients are different from those between physicians and younger patients since physicians relate differently to their aging patients (Greene et al., 1986). Ageist beliefs and practices may influence the content and process of communication. Physicians raise more psychosocial issues with the younger population, providing them with better questioning, information, and support. They are also less respectful, less patient, less engaged, and less egalitarian with their older patients (Greene, Adelman & Rizzo, 1996). It is hoped that with the emergence of the field of gerontology, professional socialization of physicians will promote more positive attitudes toward the aged. The inclusion of contact with variety of older individuals within medical school curriculum and residency training may serve as a means of dispelling ageist beliefs.

It appears that professional socialization can serve as an explanation for physicians' perceptions of elderly alcohol abuse. The literature suggests that physicians' knowledge of alcohol abuse and their attitudes toward the

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elderly population are based in socialization of the medical profession. It can be hypothesized that how physicians perceive, and subsequently deal with elderly alcohol abuse stems from their professional socialization which occurred during their medical education, through the organization of the work environment, or both. The thesis connects the findings of the study to this conceptual framework, searching for a better understanding of physicians' perceptions of elderly alcohol abuse.

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Chapter Three

LITERATURE REVIEW

Prior to data collection for this research, an in-depth review of the literature related to elderly alcohol abuse was completed. Every effort was made to find all the relevant studies available in the literature. Throughout this process it became apparent that a multitude of studies have been done on alcoholics and treatment issues, and significantly less on physicians and their perceptions of elderly alcohol abuse.

Although this study looks at physicians' perception of elderly alcohol abuse and how this perception relates to the rate of identification and treatment of elderly alcoholics, the subject of elderly alcohol abuse had to be examined to gain an understanding of the issues. The literature review included exploration of topics such as definitions of alcoholism, the prevalence of alcohol abuse among the elderly, the obstacles in identifying elderly alcohol abuse, alcohol's ill-effects on the elderly, early and late-onset of alcoholism, the treatment and success rate of elderly alcohol abuse, and physicians' identification of elderly alcohol abuse. It is believed that these topics are related to the issues explored in this research. Narrowly limiting the literature review to only one aspect of the issue may not provide the necessary background needed to explain the findings of the study.

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3.1 Definition of alcoholism

The literature points to multiple definitions of alcoholism. Jellinek (1960), a pioneer in the field of alcoholism, terms "alcoholism as any use of alcoholic beverages that causes any damage to the individual or society or both" (p. 35). He proposes several different kinds of alcoholism, although only five varieties may come into consideration as a disease: alpha, beta, gamma, delta, and epsilon. Alpha alcoholism represents a purely psychological continual reliance upon the effect of alcohol to relieve bodily or emotional pain. Beta alcoholism is indicated by alcohol related health problems which may occur without either physical or psychological dependence upon alcohol. Gamma alcoholism is characterized by acquired increased tissue tolerance to alcohol, withdrawal symptoms, cravings, and loss of control. Delta alcoholism shows the first three characteristics of gamma alcoholism as well as inability to abstain, and epsilon alcoholism is designated as periodic alcoholism (Jellinek, 1960).

Jellinek makes a distinction between alcoholism and alcoholics. He states that his definition of alcoholism does not designate as alcoholics those individuals who occasionally risk some kind of damage through their use of alcoholic beverages. He calls alcoholics only those who manifest the alpha, beta, gamma, delta and epsilon varieties of alcoholism (ibid.).

Other authors or organizations propose more general definitions of alcoholism. Cox, Jacobs, Leblanc and Marshman in their reference text Drugs and Drug Abuse (1983) look at the description of alcoholism offered by the

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World Health Organization and the Addiction Research Foundation. The World Health Organization sees alcoholism as an impairment resulting from alcohol abuse which can be manifested in a noticeable mental disturbance, or an interference with bodily and mental health, interpersonal relationships, and social or economic functioning. The Addiction Research Foundation looks at alcoholism "in terms of the quantity of alcohol consumed on a regular basis; an average consumption of at least 15 cl of absolute alcohol per day for males, and two-thirds that amount for females, is said to constitute alcoholism" (Cox et al., 1983, p. 66).

Some researchers shun away from the term alcoholism in favour of a numerical system which looks at a variety of problems related to alcohol abuse, such as legal problems or work problems. Such an approach avoids the arbitrary labeling of alcohol users as either alcoholic or not alcoholic based on a formal definition (Cox et al., 1983). A more recent definition by Morse and Flavin (1992) sees alcoholism as a chronic disease with genetic, psychological, and environmental factors influencing its development and manifestation. It is characterized by diminished control over drinking, preoccupation with alcohol, and use of alcohol despite adverse consequences in the person's health and/or social functioning.

The American Psychiatric Association (1994) in its Diagnostic and Statistical Manual of Mental Disorders (DSM-4) differentiates between alcohol abuse and alcohol dependence. According to this manual, alcohol abuse is characterized by a regular or escalating drinking pattern accompanied by adverse consequences in health or psychosocial functioning. Alcohol

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dependence implies an addiction to alcohol and includes the physiologic symptoms of tolerance and withdrawal.

The attempt to reach an agreement on a core definition of alcoholism can be problematic since criteria for its diagnosis are imprecise and ambiguous. The word 'alcoholism' is in common use, however, its meaning is hard to define since no general measures exist. An individual's use of alcohol can be considered as a point on a continuum from non-use, non-problem drinking, misuse, problem drinking, to various degrees of alcohol abuse and alcohol dependence. The dividing line where an individual is considered alcoholic is imprecise and hard to identify since its diagnosis depends on many factors such as person's age, gender, body mass, and metabolism.

3.2 Prevalence of Alcohol Abuse among the Elderly

Looking at the studies which are trying to estimate the rate of alcohol abuse among the elderly, it is very difficult to arrive at the conclusive number. When assessing the prevalence, different studies use different operational definitions such as alcohol misuse, alcohol-related problems, problem drinker, chronic drinker, alcohol abuse, and alcohol dependency. They do not necessarily identify what definition they used in their research, and very often the terms are used interchangeably. Also, the numbers can be quite varied from one study to another depending on two other factors: the setting of the study such as community or institutions, and the population group under study

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such as men, women, veterans, medical inpatients or psychiatric patients.

Blazer and Pennybacker (1984) indicate that the rates of elders with alcohol-related problems reach up to 24 percent in community studies, and up to 63 percent in clinical studies. Alcohol misuse can be nearly as common as heart disease, visual and hearing impairment and hypertension among geriatric mental health patients (Atkinson, 1987). Price and Andrews (1982) believe that alcoholism is a significant problem of the aged, estimating that 10 to 15 percent of the general elderly population suffer from alcohol-related problems. Caracci and Miller (1991) report that community prevalence rates of geriatric alcoholism can reach up to 20 percent, with much higher rates in institutions. Alexander and Duff (1988) have found the widespread use of alcohol in retirement communities where drinking was determined to be substantially greater than among the elderly in the general population.

The exact rate of alcohol abuse in Canada is not known but a conservative estimate indicates 10 to 15 percent of the elderly population can be classified as problem drinkers (Philion, 1988). The Addiction Research Foundation (1993) recommends that a safe-drinking quantity for seniors should not exceed two to three drinks per day for a male, and one to two drinks per day for a female. Jull and Adrian (1989) indicate in their study that 35 percent of elderly Canadians reported drinking five or more drinks at a single sitting which exceeds the recommended amount. The study done by the Addiction Research Foundation indicates that up to 10 percent of the general elderly population have problem drinking, rising up to 20 percent in nursing homes and homes for the aged, and up to 40 percent in institutional

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settings for older war veterans (Saunders, 1986). Genderwise, it appears that older men drink far more frequently and consume larger quantities than older women (Graham, Carver & Brett, 1995).

The researchers tend to agree that the rate of alcohol abuse usually decreases with age. Seymour and Wattis (1992) claim that alcohol intake remains high in the 65-75 age range, but falls markedly in the 75-85 age range. McKim and Quinlan (1991) demonstrate in their study that the age-related decline in alcohol consumption is a result of changes in the amount of alcohol consumed per occasion rather than a change in the number of drinking occasions.

Atkinson (1984) points to several possible explanations for reduced prevalence rate of alcohol abuse among the elderly. One of them is early mortality since many severe alcoholics do not survive to old age, biasing subsequent prevalence rate. Those drinkers who do survive may decrease their consumption of alcohol due to the increased biological sensitivity to the effects of alcohol. Also, physical symptoms may cause many people to moderate their alcohol intake in later years. Another explanation is the lower income in old age which may constrain drinking practices. Spontaneous recovery is also mentioned as an explanation since some problem drinkers eventually become abstinent, often without treatment.

Some researchers are suggesting that alcohol use of elderly people will increase substantially in the future. Alexander and Duff (1988) point to the longitudinal studies which show that the present lower rates of consumption are primarily due to a cohort effect. The current older population has always

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been a light drinking generation; however, today's middle-aged and younger adults have a higher rate of alcohol consumption, and they are expected to continue their heavier drinking into old age. Therefore, the decline in the prevalence of alcohol use with age may dissipate as the current cohort of middle-aged adults grows older (Callahan & Tierney, 1995).

The study done by the Addiction Research Foundation (1992) shows that alcohol use among the Ontario adults aged 65 and over has already increased from 53.5 percent in 1977 to 73.8 percent in 1991. Alcohol use among the elderly in Northwestern Ontario is even higher. The Thunder Bay Drug Awareness Committee (1994-95) indicates a 6 percent higher alcohol consumption rate among the region's seniors in comparison to the rest of Ontario.

Even if the prevalence of alcohol use remains constant during the next two decades, the growing proportion of seniors in the population will result in an increased number of individuals experiencing alcohol related problems (Smart & Adlaf, 1988). Prevention, early identification and treatment of abusive drinking among the elderly will become more of a public health issue than it is at the present time.

3.3 Obstacles in Identifying Elderly Alcohol Abuse

Studies of alcohol abuse among the elderly point to a number of obstacles which can contribute to the underreporting of cases, thus skewing

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the rate of alcohol abuse in old age. There are several identified factors which can contribute to the inaccuracy in prevalence rates.

The older drinker may be hard to detect since alcohol abuse assessment questionnaires are primarily designed to identify younger individuals, relying on indicators such as job-related issues and troubles with the law. These indicators may not be present in the older individual (Schonfeld & Dupree, 1990; Seymour & Wattis, 1992). Alcohol consumption as a measure of alcohol abuse can also present a problem since the elderly show decreased tolerance and more extreme effects of alcohol than other age groups (Graham, 1986). Additionally, elderly abusers tend to be middle class and conform much less to 'skid row' stereotype than do younger individuals (Atkinson, 1984).

Compared to the younger population, the aged are more reluctant or even completely unwilling to be evaluated (Solomon, Manepalli, Ireland & Mahon, 1993). The denial of alcohol abuse is much greater among the elderly than among other age groups. Many of the present elderly individuals lived through the Prohibition and the Depression which might have generated negative attitudes toward alcohol consumption (Adams et al., 1992).

Elderly alcoholics are not usually seen inebriated in public since they prefer to drink at home, keeping a low profile (Eliany, 1991; Schonfeld & Dupree, 1990; Single & Wortley, 1993). Many seniors are retired and living alone, so problems with alcohol abuse may go undetected by family members, friends, employers, or co-workers (Atkinson, 1984).

Social problems used as markers of alcohol abuse among the general

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population, such as physical aggression, breaking the law, and intoxication while driving or working, tend to miss the elderly (Graham, 1986). Elderly people may underestimate their alcohol intake, or conceal the true extent of their drinking more than younger people (Seymour & Wattis, 1992). Self-recognition is low since they do not perceive alcoholism as a disease to which they can admit and seek help for (Graham, 1986). Their families often indulge the abuse by protecting the elderly and letting them enjoy their drinks (Champlin, 1983), or they may be ignoring the seriousness of the problem (D'Archangelo, 1993).

All these identified obstacles in recognizing elderly alcohol abuse underline the importance of physicians' role in discovering and identifying problem drinkers. As previously stated, primary care physicians are well placed to diagnose alcohol abuse. Trusted and visited by older patients on a regular basis, they can observe medical complications of alcohol abuse presented to them, and they may also have knowledge of the patient's family and social circumstances. Primary care physicians are in a position to offer education on prevention and safe drinking, to suggest medical and social intervention, or to refer elderly alcoholics to treatment facilities.

3.4 Alcohol's Ill-Effects on the Elderly

The elderly are highly vulnerable to the effects of alcohol due to the decreased lean body mass which occurs with aging (Schuckit, 1982). The

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intake levels that might not cause trouble in youth or middle age can do so in older adults (Atkinson, 1987; Brody, 1985; Garver, 1984; Seymour & Wattis, 1992; Stern & Kastenbaum, 1984). Age-related changes in the distribution and metabolism of alcohol may result in increased sensitivity to and prolonged effects from low levels of alcohol (Miller, Belkin & Gold, 1991). A person can begin to experience alcohol-induced problems simply by becoming older, without changing the amount of alcohol consumed (Bienenfeld, 1987).

Alcohol abuse can pose a serious problem among the aged, claiming a very high medical and social toll (Crook & Cohen, 1984), since aging organs are less able to withstand the toxic effects of alcohol (Seymour & Wattis, 1992). The prognosis for untreated alcoholism in the elderly is poor (Miller et al., 1991). Callahan and Tierney (1995) report that seniors with evidence of alcohol abuse have greater morbidity and mortality rates. Prescribed and over-the-counter medications, which many elderly use in significant amounts (Elliot, Hunt & Hutchison, 1996; Philion, 1988), can intensify the effects of alcohol, causing physical, psychological, and social dysfunction (Solomon et al., 1993). Also, it is not uncommon for the elderly to misuse medications or confuse prescription instructions, compounding the alcohol use problem (Folkman, Bernstein & Lazarus,1987; Kimberley, 1985).

The list of alcohol's ill-effects on the elderly is extensive. It affects every system of the body, especially the digestive, nervous, circulatory, muscular and endocrine systems. Research confirms that alcohol can cause liver, brain and heart disease, and it is also linked with Alzheimer's disease and

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osteoporosis (Philion, 1988). The elderly experience greater problems with alcohol-related medical conditions than their numbers in the population would suggest. Although comprising only 11.6 percent of the total population in Canada (Statistics Canada, 1991), the elderly account for twice as many hospitalizations for such conditions as alcoholic psychosis and chronic liver disease, and they also represent 35 percent of all alcohol-related deaths (Jull & Adrian, 1989). The Addiction Research Foundation (1995) reports that in Canada in 1991 the highest rate of death from direct alcohol-related problems per 100,000 population was 50.9 which was found in the 65 to 69 age cluster, followed by 48.6, found in the 70 to 74 age cluster.

Alcohol abuse in the elderly may also lead to a number of psychiatric consequences such as irritability, apathy, delusions, hallucinations, memory loss, sleep disturbances, and decrease in the activities of daily living (Solomon et al., 1993). Drinking problems in later life can also increase the chance of suicide since alcohol depresses the central nervous system, causing or intensifying depression (Pratt, Wilson, Benthlin & Schmall, 1992). Osgood (1985) reports that alcohol abuse is associated with suicide attempts in 5 to 20 percent of drinkers over age 60. Greater alcohol intake is also associated with lower social fulfillment, lower life satisfaction, and greater negative feelings (Adlaf, Smart & Jansen, 1989).

For all these reasons, it is important to identify and treat older problem drinkers. The potential advantages of treatment may lessen elderly people's burden of unnecessary illness, increase their quality of life, and diminish health care needs.

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3.5 Early and Late-Onset of Alcohol Abuse

Older problem drinkers can be classified into two major categories: the aging alcoholic and the geriatric alcoholic. The aging alcoholic, or the early-onset elderly alcohol abuser, is described as a person who has been abusing alcohol most of his/her life and continues this pattern into old age. The geriatric alcoholic, or late-onset problem drinker, began heavy drinking late in life (Schonfeld & Dupree, 1990). Early-onset alcohol abusers have recognized behaviour problems and personality characteristics similar to younger alcoholics. The late-onset alcohol abuser is described as a reactive drinker, developing drinking problems late in life in response to the stresses related with aging (Schonfeld & Dupree, 1991).

Seymour and Wattis (1992) identify several different characteristics found in each subtype of elderly abusers. Aging alcoholics are more likely to have a family history of alcohol abuse, be heavy smokers, and consume a greater quantity of alcohol. The geriatric alcoholics are more likely to have an obvious precipitant for drinking, such as medical, social, and/or psychiatric reasons. Loneliness is a common contributory factor. Drinking may start or escalate after a bereavement, and excessive drinking may also be used for temporary relief of medical symptoms. The geriatric alcoholics tend to have a milder drinking problem.

Similar findings are shown in a study by Atkinson, Turner, Kofoed and Tolson (1985). They report no statistically significant differences between the two subtypes of elderly alcoholics in relation to their sex, age, marital status, or

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home ownership. However, the early-onset alcoholics tend to have had legal problems related to alcohol use. There is also a striking difference in reported family alcoholism between the two groups. Family alcoholism was far more common in the early-onset abusers. They also showed evidence of greater psychopathology.

Adams and Waskel (1993) report that many late-onset alcoholics are divorced or widowed. Their study concludes that a spouse may provide an element of control over the older person's drinking. The chances for developing alcohol abuse problems may increase when the spouse is absent through death or divorce. Dupree, Broskowski & Schonfeld (1984) claim that late-onset alcohol abusers lead fairly successful lives, providing for themselves through their own skills and resources. They use alcohol as a palliative in response to cumulative losses and stresses associated with aging.

Schonfeld and Dupree (1990) suggest that despite the differences between the two groups of older problem drinkers, there is a similarity in their drinking behaviour which is due to age-related problems. Regardless of the onset of the drinking problem, most elderly in their study experienced losses and stresses commonly associated with aging, such as widowhood and meager social support networks. Both groups reported feelings of loneliness and depression. However, early-onset drinkers were intoxicated more frequently, and they experienced more severe emotional problems.

Brody (1985) identifies four factors that promote elderly alcohol abuse, regardless of the age of onset. These factors are: (1) retirement, combined with boredom, change of role status, and loss of income; (2) death occurring

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among relatives and friends; (3) poor health and discomfort; and (4) loneliness, particularly among elderly women. Hubbard and Carrol (1992) report that alcohol is often playing the role of an analgesic and coping mechanism.

There seems to be no agreement among the researchers which group constitutes the majority of older problem drinkers. Brody (1985) suggests that two thirds of elderly abusers are the early-onset or aging alcoholics. Nevertheless, both groups respond equally well to treatment (Schonfeld & Dupree, 1991).

3.6 Treatment of Elderly Alcohol Abuse

Evidence suggests that elderly alcoholics can be treated quite successfully. A study done by Carstensen et al. (1985) shows that 50 percent of the elderly who received treatment were successfully abstaining from alcohol between two and three years after completion of the program, and an additional 12 percent significantly decreased alcohol intake. It appears that older problem drinkers respond as well as or better to treatment than younger alcoholics (Atkinson, 1987; Brody, 1985; Evans, Street & Lynch, 1996; McKim & Mishara, 1987; Mishara, 1985; Philion, 1988). It also seems that their chances for successful rehabilitation are greater. In a five to eight-year follow-up of treated alcoholics, Helzer (1984) reports a better success rate among the elderly than among younger patients.

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The literature points to several different modalities of treatment. Atkinson (1984) maintains that the treatment requirements for older persons are similar to those for all patients. The initial hospital management of very poorly controlled or medically complicated cases is followed by longer-term outpatient rehabilitation based on abstinence. Zimberg (1984) believes that group therapy, socialization, and antidepressant medication are effective in eliminating alcohol abuse among the elderly. He maintains that treatment for elderly alcoholics is most likely to be successful if it is directed at the social and psychological stresses associated with aging since the elderly alcoholic is responding to these stresses by drinking. By lessening or eliminating these stresses, the secondary use of alcohol is diminished, thus leading to sobriety (Zimberg, 1985). Mandatory AA attendance may not be appropriate for elderly persons because they may find it difficult to relate to the younger individuals who make up a larger proportion of the attendance at those meetings (Cohen, 1988; Zimberg, 1984).

F. M. Friedman, C. J. Friedman and Skoloda (1985) identify several factors which may serve as barriers to effective treatment of elderly alcoholics. The first barrier is lack of information about aging itself. There is a great deal of misinformation in our society about old age as a stage of life. The second major barrier to effective treatment of the elderly is a lack of understanding of the psychology of the elderly. Any treatment program must recognize the psychological differences between the elderly and the other age groups. The last barrier is a lack of appreciation for the significance of family relationships in the treatment of elderly patients. Only by shedding off these obstacles can

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the treatment of elderly alcoholics be successful.

Programs designed especially for the elderly seem to be more effective than standard treatment models (Evans et al., 1996). Some authors claim that a peer-group approach fosters greater compliance with and completion of treatment by the elderly than they are able to achieve in the mainstream treatment program. The sharing of experiences among members and the supportive relationships that are developed in the group may be particularly beneficial for the older drinker who may be often socially isolated (Kofoed, Tolson, Atkinson, Toth & Turner, 1987).

Community-based intervention models have been devised specifically for elderly substance abusers (Holmstrom, 1990). Two major ones are the Lifestyle Enrichment for Senior Adults program (LESA) in Ottawa, and the Community Older Persons Alcohol Project (COPA) in Toronto. These community models aim at providing adequate nutrition and health care, treating depression when appropriate, helping the elderly to solve personal problems without resorting to alcohol, developing social relationships, and providing significant leisure activities to replace drinking (Mishara, 1991). Another senior-specific treatment program, modelled after COPA, is Victoria Innovative Seniors Treatment Approach (VISTA) which is located in Victoria, B. C. Using a client-centred, nonjudgmental, nonconfrontational model, VISTA promotes positive lifestyle changes that foster improved health, better quality of life, and increased independence (Evans et al., 1996).

This current literature suggests a trend in changing treatment modalities for elderly alcohol abusers. It appears there is a move toward

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community-based interventions which emphasize a holistic approach to treatment. Unfortunately, these age-specific intervention models are not readily available across Canada.

Currently in Thunder Bay, an elderly alcoholic has a choice of three available treatment services: Alcoholics Anonymous, The Sister Margaret Smith Centre, and The Lakehead Addiction Centre. These programs are aimed at the general population, and do not have a treatment model specifically designed for the elderly. The Sister Margaret Smith Centre consists of adult outpatient services, as well as a Three Phase Residential Treatment Program. The Lakehead Addiction Centre, located within the Lakehead Psychiatric Hospital, offers an integrated case management and addictions treatment program for persons experiencing a concurrent disorder of addictions and mental health disability (Majcen, 1996).

Despite research findings, showing that elderly alcohol abuse can be treated successfully, the elderly as a population under utilize substance abuse treatment services (McKim & Mishara, 1987; Schonfeld & Dupree, 1990). Schonfeld (1993) suggests that older problem drinkers constitute less than two percent of admissions to alcohol treatment programs. In Ontario, 1,403 individuals aged 65 and over utilized alcohol/drug treatment facilities during 1988-89, which represents 2.5 percent of the total population in these facilities (Tyas & Rush, 1994). Low utilization rates might be due to inability of the system to identify elderly with alcohol problems (Schonfeld & Dupree, 1990).

Evidence from treatment facilities suggests that elderly alcoholics do not self-refer to addiction programs (Graham, 1986). This is consistent with

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local data. Most of the elderly in treatment programs in Thunder Bay are referred by medical professionals. The Sister Margaret Smith Centre in Thunder Bay reported that in 1994 only two percent of their 574 patients were 65 years of age or older, and most of them were referrals from primary care physicians (Mulligan, 1996).

Anecdotal evidence suggests that a substantial proportion of the elderly who seek medical attention for any reason have an alcohol related problem; therefore, detection during these encounters could have great value for identification (Brody, 1985). The research shows, however, that medical practitioners are not assuming the role of diagnosing, referring and treating elderly abusers with any regularity, effectiveness or enthusiasm (Coulehan et al., 1987; Curtis et al., 1989; Moore et al., 1989; Philion, 1988). Interactions to modify these physicians' behaviours would therefore greatly benefit elderly alcohol abusers.

3.7 Physicians' Identification of Elderly Alcohol Abuse

Although in the last twenty years a vast number of studies have been done on alcohol abuse, the issue of physicians' identification of elderly alcohol abuse has received limited attention. The available literature suggests that physicians are not very successful at identifying alcohol abuse among their patients of any age. The study done by Coulehan et al. (1987) shows that of 294 adult primary care patients, diagnosed by a structured psychiatric

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interview as alcohol abusers, only 40 percent were identified by primary care physicians as having a substance abuse problem. Similarly, Moore et al. (1989) report in their study that detection rate of alcoholism by physicians for those patients who screened positively were less than 25 percent in surgery, between 25 and 50 percent in neurology and internal medicine, and greater than 50 percent in psychiatry. Physicians were less likely to identify as alcoholics those patients who denied heavy alcohol intake, those with higher incomes and higher education, and women.

It appears that physicians are even more likely to underdiagnose alcohol abuse among their patients who are older. A study done at The Johns Hopkins Hospital shows that physicians correctly detected 60 percent of the non-elderly patients as alcoholics, but only 37 percent of elderly patients were similarly identified. Intervention was recommended to 50 percent of non-elderly alcohol abusers, and only to 24 percent of the elderly patients diagnosed as alcoholics (Curtis et al., 1989). Adams et al. (1992) report in their study that physicians in the emergency department detected only 21 percent of elderly patients who were previously identified as alcohol abusers.

The study done on prevalence of alcoholism in primary care medical practices shows that 10 percent of older patients had current evidence of alcoholism. However, fewer than half of those had documentation of alcohol abuse in their medical records (Callahan & Tierney, 1995). It appears that not only the patient's age but also the patient's gender effects physicians' identification rate.The study done by Lichtenberg et al. (1993) demonstrates that although one-half of the elderly male alcohol abusers were correctly

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detected, no alcohol abusing elderly female was correctly identified.

Research done to date to determine the causes of low recognition of elderly alcohol abuse by physicians has been limited, looking at only one or two issues. Different studies attribute the low rate of identification to different factors: lack of medical training specific to alcoholism (Canadian Medical Association, 1993), perceived lack of skill (Moore et al., 1989), attributing alcohol-related health problems to age-related health problems (Schonfeld & Dupree, 1990), restricting the attention to the complications of alcoholism rather than the disease itself (Kamerow et al., 1986), failing to ask the elderly patients about alcohol use (Willenbring & Spring, 1990), being more discreet and less confrontative with older patients (Mignon, 1993-94), sharing the ambivalence of the general population toward alcohol and alcohol-related problems (Peters et al., 1996), pushing a problem aside as too difficult and not worth tackling (Tabisz, Jacyk, Fuchs & Grymonpre, 1993), and reluctance to separate the patient from what it may be seen as his/her one remaining source of pleasure (Stern & Kastenbaum, 1984).

Review of the literature suggests that the issue of the low identification rate of elderly alcohol abuse by medical practitioners needs further exploration. Each of the identified factors from different studies can be seen as only part of the barrier to successful detection of alcoholism. Research looking at all of these factors at the same time, and based on the reported experiences of practicing physicians, may provide a better understanding of the problem, leading to practical suggestions for higher recognition rates of alcohol abuse among the elderly.

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Chapter Four

METHODOLOGY

4.1 Proposition and Research Questions

Review of the available literature points to several facts with regard to elderly alcohol abuse. It has shown that alcohol abuse is a problem among the older population. Although the proportion of the aged affected by drinking problems may not be high, abusive alcohol consumption appears to be particularly toxic in the elderly, claiming a very high medical, psychological and social toll. The available research shows that elderly alcohol abuse can be treated quite effectively, although many obstacles in identifying this problem may prevent successful rehabilitation. Demographic predictions indicate that the proportion of the elderly population will increase substantially, and with it the alcohol related problems of this age group. The costs of elderly alcohol abuse are not only high for the aged but also for the community as a whole which makes it imperative that attention is focused on the identification and treatment of this problem. Numerous studies argue that physicians can play a large role in detection of elderly alcohol abuse; however, the research indicates that the identification and treatment rates of elderly alcohol abuse by physicians are quite low.

The intent of this thesis is to explore the issue of under-diagnosing of

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elderly alcohol abuse by primary care physicians. Specifically, the main purpose is to answer the question: what are the causes for the low recognition and treatment rate of elderly alcohol abuse by primary care physicians? The following research questions were identified to provide the direction for this study:

(1) Why are primary care physicians not recognizing and/or treating elderly alcohol abuse at a higher rate?

(2) What are the barriers to better identification and subsequent treatment of elderly alcohol abuse by primary care physicians?

(3) To what degree are primary care physicians interested in addressing older patients' drinking problems?

(4) What are primary care physicians' self-perceived attitudes toward elderly alcohol abuse?

This thesis explores the relationship between physicians' perceptions of elderly alcohol abuse and the low rate of identification and treatment. Physicians' knowledge and attitudes toward alcohol abuse and older patients, stemming from professional socialization, may affect physicians' detection and intervention of elderly alcohol abuse. This study looks at primary care physicians, and their self-perceived responses to drinking problems of their older patients. Specifically, the objective is to identify the variables that have an impact on recognition and treatment rate of elderly alcohol abuse.

A study of physicians' perceptions of elderly alcohol abuse is important for several reasons. First, the knowledge gained from this study can contribute to the research and literature in the field of elderly alcohol abuse. By focusing

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on the problem that is often hidden and not identified, the study may point to the issues that might have been overlooked previously. Second, understanding a relationship between physicians' perceptions of elderly alcohol abuse and the low identification rate can help reveal the underlying causes of the problem. And third, looking concurrently at all previously identified factors for low recognition may provide better understanding of the problem. Therefore, the study can serve as input to practical suggestions which may improve the recognition and treatment rate of elderly alcohol abuse by primary care physicians.

4.2 Conceptual and Operational Definitions

Within the research instrument and throughout the description of the findings, certain terms have been frequently used which need to be clarified by definitions.

The term 'primary care physician' relates to a general practitioner, or a family physician, who actively practices primary care medicine, and sees his/her patients on a regular basis.

The term 'elderly' refers to persons aged 65 and over. This age range was chosen since most of the conventional literature uses it as a marking point to define the senior population. Also, our society recognizes the age of 65 as a passage from middle to old age, marked by retirement and social security programs. This definition was mentioned to physicians at the

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beginning of the the data collection process.

As shown in Chapter Three, it is very difficult to arrive at the conceptual definition of 'alcoholism' due to the imprecise and ambiguous criteria for the diagnosis. As an operational definition used in this study, a definition of alcoholism most likely to be familiar to physicians was applied. It is believed that physicians share a common epistemological orientation which is textually and socially derived from their professional socialization. For this purpose, Harrison's Principles of Internal Medicine (13th edition), published in 1994, was utilized since this source is commonly used as a textbook in medical schools and as a reference manual in physicians' work environment.

The definition of alcoholism, found in this source, closely follows a definition given by American Psychiatric Association (1994) in its DSM-4. Alcoholism is divided into alcohol abuse and alcohol dependence. Alcohol abuse indicates alcohol-related life impairment interfering with functioning. A dependence encompasses similar impairment along with evidence of a strong compulsion to use alcohol, accompanied by increased tolerance or physical signs on withdrawal from alcohol (Schuckit, 1994).

Since physicians are mainly concerned with the effects of alcohol consumption, a modified approach to a definition of alcoholism is also proposed in Harrison's Principles of Internal Medicine as it is easier to apply in clinical settings. The diagnosis of alcoholism can be made when an individual ignores the early warning signs that he/she is experiencing alcohol-related problems in health, interpersonal relationships, employment, law, or social interactions. Thus, the clinical diagnosis of alcoholism rests on

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documentation of a pattern of problems associated with alcohol use and it is not based on the quantity and frequency of alcohol consumption (ibid.).

4.3 Research Instrument and Data Collection

A survey questionnaire was selected as an instrument to gather relevant data for this study. There are several advantages of this research instrument that played a role in its selection. Primary care physicians, as the subjects of this study, are reluctant to devote a significant amount of time to any research projects due to their busy schedules and large workloads. A survey questionnaire can gather considerable information in a limited time available with each participant (Babbie, 1983). A survey is also seen as an appropriate method since it can be used for descriptive, explanatory, and exploratory purposes used in studies that have individual people as the units of analysis, and it can be an excellent method for assessing attitudes (ibid.).

The survey questionnaire used in this study was designed by myself since no appropriate data collection instrument examining physicians' perceptions of elderly alcohol abuse was located in the literature. With the identified research questions serving as a focal point, the development of the questions was guided by existing literature on physicians' professional socialization, and on elderly alcohol abuse and its recognition by physicians.

The designed questionnaire (see Appendix A for the copy of the questionnaire) addressed the research questions through four main

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categories:

- general characteristics of primary care physicians and their practices;
- brief self-assessment of the respondent's alcohol abuse training;
- physician's subjective assessment of the prevalence, identification and treatment rate of elderly alcohol abuse in his/her own practice; and
- physician's self-perceived attitudes toward elderly alcohol abuse.

The quantitative nature of this questionnaire provided a standardized framework for data analysis. However, such a questionnaire, with its limited data collection and closed-ended questions may potentially miss certain relevant information (Babbie, 1983). The use of different research methods, such as integration of qualitative and quantitative approach within the same study may establish a more complete picture of the investigated phenomenon (Creswell, 1994; Prein, Kuckartz, Roller, Ragin & Kelle, 1985).

Since a questionnaire with quantitative content can limit the participant's answers, a supplementary questionnaire gathering limited qualitative data was also developed. This questionnaire was designed to measure the same variables as the first one; however, its design with open-ended questions provided the respondent with an opportunity to expand on the topic, to express freely his/her opinions, and to add any comments (see Appendix B for the copy of the supplementary questionnaire). Such an approach provides direct quotations from participants about their experiences, beliefs, and attitudes (Patton, 1980). Therefore, the supplementary questionnaire was used to confirm the findings from the first questionnaire, and to examine the consistency of the obtained data, giving it its validity.

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Both questionnaires were pre-tested on two male and one female primary care physicians to assess the appropriateness, clarity and validity of the questions. The participants interviewed at the pre-test stage were also asked to comment on the proposed strategies to maximize the response rate and to gain access to individual physicians.

The target population for this study was primary care physicians, such as family and general practitioners, since they are seen as the ones who encounter elderly patients in their practice on a regular basis, providing direct care or routine treatment.

The study was done in Thunder Bay between September and November 1996, using the Thunder Bay Medical Society record of physicians as a sampling frame (refer to Appendix C for an example of the list). At the time of the study, there were 68 family and general practitioners on the list who actively engaged in a regular primary care practice in Thunder Bay.

The invitation letter to participate in the study was personally delivered to all of these physicians (refer to Appendix D for the sample of the invitation letter). To insure the highest possible participation rate, a follow-up phone call was placed when a response to the invitation letter was not received within two weeks.

The meeting time was set up with each respondent individually, and every participant was asked to read and sign the consent form, agreeing to participate in the study (refer to Appendix E for the sample of the consent form). A questionnaire with quantitative content was administered in an interview format face-to-face as it is believed that this data collection method

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offers a higher response rate and fewer incomplete questionnaires than mail-in method (Babbie, 1983). A few physicians offered comments with their answers, and these remarks were written down verbatim and included in the analysis of the findings. All meetings with the participants took place in physicians' offices, spending on average 15 to 20 minutes with each physician.

After administering the questionnaire, the supplementary questionnaire with an addressed and stamped envelope was left with each physician. Every participant was asked to respond to this questionnaire in his/her free time, and mail it back within two weeks. A note to thank the respondents for participating in the study was sent shortly after the meeting.

The proposal for this research was approved by the Ethics Advisory Committee of Lakehead University, and every effort was made to ensure compliance to the Social Science and Humanities Research Council of Canada's Ethics Guidelines for Research with Human Subjects. All of the participants were informed about the purpose of the research and the ability to withdraw from the study at any time. They were also reassured about the confidentiality of the study. The participants were never subjected to situations which in any way posed a threat to their physical or psychological well being. All of the questionnaires were coded to assure confidentiality, and participants' names or any identifying information were never linked to the obtained findings. As required by ethical guidelines of Social Science and Humanities Research Council of Canada, the collected data will be stored for a period of seven years in secure and confidential storage.

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4.4 Data Analysis

The target population for this research consisted of 68 family and general practitioners, out of which 28 or 41.2 percent agreed to participate in the study. Although the response rate can be considered relatively high for this target population, it does not provide a basis for generalizing the findings beyond the participant sample. Rubin and Babbie (1989) state that a response rate of 50 percent or higher is needed to draw conclusions which can be applied to the general population. Nevertheless, the findings can be used for descriptive purposes of subjects studied, indicating prevailing tendency and general direction.

Following data collection, the completed questionnaires were coded according to location of practice, such as north or south ward, clinic or independent practice. The coding list was kept separate from data at all times.

Data obtained from the questionnaire with quantitative content was analysed using the SPSS computer package. Since the number of respondents was relatively low, the focus of analysis was limited to the collected data in hand and no inferential statistics was used. Therefore, no tests of statistical significance were performed. However, descriptive analysis was applied to describe and interpret data in hand, employing univariate and bivariate analysis.

The univariate analysis was used to describe one variable at a time, measuring distribution, central tendency, and dispersion. The examined variables can be grouped in the following general categories: 1) physicians'

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characteristics, such as gender, age, years practicing medicine, and location; 2) characteristics of physicians' practices, such as number of patients seen per week, percentage of elderly in the practice, and frequency of older patients' visits; 3) alcohol abuse training in medical school, and through continuing medical education courses; 4) confidence in diagnosing and treating elderly alcohol abuse; 5) estimates of problem drinking among physicians' elderly patients; 6) percentage of diagnosed elderly alcohol abusers referred to treatment; 7) alcohol treatment modalities; 8) feelings of success in helping older patients overcome drinking problems; 9) routine questioning about alcohol consumption; and 10) attitudes toward identification, diagnosis, and treatment of elderly alcohol abuse.

Collected quantitative data was also examined on a deeper level. Bivariate analysis was used to describe and compare subgroups, and to explore the relationship between different variables. The independent variables used in bivariate analysis were: 1) gender; 2) age; 3) training on alcohol abuse; 4) number of patients seen per week; 5) percentage of elderly patients in the practice; 6) estimates of problem drinking among physician's elderly patients; 7) percentage of elderly alcoholics referred to treatment; 8) routine questioning about alcohol consumption; and 9) usage of a standardized questionnaire for assessing drinking behaviour of older patients. Such analysis allowed for comparisons to be made among different subgroups, and it also provided the identification of variables that have an impact on recognition and treatment rate of elderly alcohol abuse.

Out of 28 physicians who participated in the survey, 21 or 75 percent

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returned the supplementary questionnaire. The individual responses from returned questionnaires were grouped together for each question. These qualitative answers were used as a support and illustration of quantitative data.

4.5 Limitations

There are several limitations of this study which need to be acknowledged. Due to the relative low number of physicians who participated in the study, the findings can not be generalized beyond the participant sample. Nevertheless, the findings may indicate general tendency, and therefore are valuable for discussion and suggestion of trends.

There is also a limitation with regard to the research instrument. Data collected from the questionnaire and the supplementary questionnaire was not first hand observational data. This study relies upon the perception and sincerity of the participant, as well as the accuracy of his/her memory. Since physicians were told the purpose and the goal of the study in the invitation letter, it is likely that only those physicians who are interested in the research topic responded to the invitation. Therefore, it is believed that the participants' responses were candid and genuine.

Data obtained from the questionnaires is limited in scope and extensity. With the awareness of the physicians' large workloads and their unwillingness to participate in a lengthy survey questionnaire, a time constraint was put on

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the duration of the meeting with each participant. Due to the limited time available with each physician, a careful selection of the questions was made, and not all of the desired issues could be explored. Nevertheless, it is believed that this research serves as a step toward gaining more information and knowledge about physicians' perceptions of elderly alcohol abuse. Additional studies in the future can build upon the findings from this research, and expand them on the desired topics.

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Chapter Five

RESULTS

Data collected from the quantitative and supplementary questionnaires is presented in this chapter. The analyzed data is addressed through four categories which serve as a main structure for the description of the results: (1) general characteristics of physicians and their practices; (2) physicians' alcohol abuse training; (3) identification and treatment rate of elderly alcohol abuse in physicians' practices; and (4) physicians' attitudes toward elderly alcohol abuse.

5.1 General Characteristics of Physicians and their Practices

A total of 28 physicians agreed to participate in this research. The participants are described in terms of general characteristics, such as gender, age, years of practicing medicine, and location of practice. The characteristics of physicians' practices are also examined, with regard to the number of patients seen per week, percentage of elderly in the practice, and frequency of older patients' visits. This assessment of physicians and their medical practices provides a picture of the participants in the study.

Table 1 presents the frequency and percentage distribution for such

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variables of physicians' general characteristics as gender, age, years practicing medicine, and the location of practice.

Table 1: General Characteristics of Physicians

Variable	f	%
Gender		
Male	20	71.4
Female	8	28.6
	28	100
Age		
≤ 40	6	21.4
41 - 50	13	46.4
≥ 51	9	32.2
	28	100
Years Practicing Medicine		
1 - 15	10	35.7
16 - 25	11	39.3
26 +	7	25.0
	28	100
Location Practicing Medicine		
Office	28	100. 0
Community Health Clinic	4	14.3
Acute Care Hospital	28	100.0
Chronic Care Hospital	19	67.9
Nursing Home	21	75.0
Home Visits	25	89.3

Out of 28 participants, there are 20 men or 71.4 percent, and 8 women or 28.6 percent. Genderwise the participant sample is representative of the target population which is comprised of 73.5 percent of men and 26.5 percent

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of women.

The youngest respondent is 31 years old, and the oldest is 74 years old. The mean age of the participants is 47. To make the comparison between different ages possible, the respondents were grouped into three age groups: the youngest physicians (40 years old and younger), the middle age group (41 to 50 years old), and the oldest group (51 years old and over). The youngest group comprises 21.4 percent of the sample, the middle age group makes up 46.4 percent, and the oldest group 32.2 percent. There are no female physicians in the oldest group.

The respondents' length of time working in medical practice ranges from 3 years to 46 years, with mean length being 21 years. As Table 1 suggests, physicians were grouped into three categories with regard to the length of time in medical practice: 1 to 15 years, 16 to 25 years, and 26 or more years.

Table 1 also points out that all the participants are practicing both in the office and acute care hospitals, 89.3 percent provide home visits, and about three quarters of them visit their patients in chronic care hospitals and nursing homes. Only 14.3 percent work in community health clinics. Men are more likely to practice in chronic care hospitals, and more older physicians tend to visit nursing homes. Women and younger participants are more likely to be engaged in community health clinics. Only one respondent provides medical services at the Sister Margaret Smith Centre, in addition to practicing in the office, acute and chronic care hospitals, nursing homes, and home visits.

The survey also looked at the general characteristics of physicians' practices, exploring the variables such as the number of patients seen per

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week, the percentage of patients in the practice who are 65 years of age or older, the percentage of older patients seen per week, and the frequency of older patients' visits.

Data suggests that the average number of patients seen per week is 150, with the range from 56 to 300. The physicians' estimations of the percentage of their patients who are 65 years of age or older ranges from 10 to 70 percent, with the mean being 34.5 percent. The average ratio of male to female elderly patients is 35 percent to 65 percent. None of the physicians indicated that they predominantly serve a specific ethnic population in the community.

The respondents estimated that on average 41 percent of the patients seen in a given week are 65 years of age or older. This number suggests that the elderly in Thunder Bay utilize the services of primary care medicine more than their numbers in the population would suggest.

The physicians also indicated that they see an older patient quite frequently. Over half of respondents estimated that on average an elderly patient visits them every three months, with a quarter of the physicians stating that an older person comes to their office once a month. Female and the middle age group physicians see an individual elderly patient most often.

The number of patients seen per week, the percentage of elderly in the practice, and the percentage of elderly patients seen in a given week vary with age and gender of the participants. Male physicians, and the respondents from the youngest and the oldest age groups see more patients per week. Male physicians also have more elderly patients in their practices, and

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participants from the oldest age group are the only ones who estimated that more than half of their practice is comprized with patients who are 65 years old or older. Therefore, the oldest physicians also see more elderly patients in a given week than their younger colleagues.

5.2 Physicians' Alcohol Abuse Training

The physicians were asked to subjectively assess the amount of training on alcohol abuse they received in medical school and through continuing medical education. Research done to date identifies several factors which may contribute to the low recognition rate of elderly alcohol abuse, such as perceived lack of skill (Moore et al., 1989), attributing alcohol-related health problems to age-related health problems (Schonfeld & Dupree, 1990), and pushing a problem aside as too difficult to tackle (Tabisz et al., 1993). All of these identified factors can be connected to the lack of medical training specific to alcoholism. Therefore, the respondents' self-assessment of their own training on alcohol abuse is seen as an important variable which may have an impact on recognition and treatment rate of elderly alcoholism.

The physicians were asked to indicate how much training on alcohol abuse they received in medical school. Data shows that 89.3 percent of respondents obtained minimal or no training on alcohol abuse. Only 7 percent of participants indicated that they received extensive training, and one physician was not able to provide an answer.

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Out of 21 physicians who returned the supplementary questionnaire, three participants expressed their regrets about not receiving enough training in medical school, and 16 physicians described their training on alcoholism with such terms as "limited...basic...minimal...very poor". One of these respondents stated that there is a "need to increase medical schooling for identification and treatment of alcohol abuse". Only two physicians indicated that their training was "good...excellent", with one of them pointing out that a six-week alcohol treatment course was part of the family medicine program. All of the physicians who estimated that elderly patients comprise more than half of their medical practice received only minimal training.

The amount of education on alcohol abuse obtained in medical school varies according to the participants' gender and age. Findings suggest that female physicians and respondents from the youngest age group received more training in medical school than the rest of the physicians.

Respondents in the study were also asked to indicate whether they participated in any continuing medical education addressing identification, diagnosis and treatment of alcohol abuse. Data shows that about three quarters of the respondents attended some continuing education seminars, primarily on diagnosing and treatment of alcohol abuse, and about half of the physicians attended seminars addressing identification. The attendance at continuing medical education was higher among physicians from the middle and oldest age groups which can be attributed to a longer time of practicing medicine. Genderwise, there is no significant participation difference in seminars on diagnosis and treatment; however, female physicians attended

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more training on identification of alcohol abuse.

Physicians were asked to subjectively assess their knowledge about identification and treatment of elderly alcohol abuse by choosing a numeric value between 1 and 5, with 1 indicating poor knowledge and 5 suggesting excellent knowledge. Almost 80 percent of physicians picked number 3 or lower, and only 5 percent chose number 5. These figures indicate that respondents themselves do not perceive their knowledge on identification and treatment of elderly alcohol abuse as very good.

Similar findings can be observed when looking at the confidence of physicians in diagnosing and treating elderly alcohol abuse. Participants indicated their confidence by choosing a number on a scale between 1 and 5, with 1 meaning not confident and 5 being very confident. Of all the respondents, over half picked number 3 or lower on the confidence scale for diagnosing, and 64.3 percent chose number 3 or lower for treating elderly alcohol abuse. Participants from the middle and the oldest age groups expressed more confidence than the youngest respondents, and women were almost twice as likely as men to feel confident. Physicians who see the most patients per week expressed the least confidence in diagnosing and treating elderly alcohol abuse.

The amount of training on alcohol abuse in medical school does not appear to be a major variable determining physicians' confidence in diagnosing elderly alcohol abuse since there is no difference in confidence between those participants who received extensive training and those who received none. However, the respondents with extensive training felt more

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confident in treating elderly alcohol addiction.

A noticeable difference in confidence appears when the continuing medical education variable is introduced. The following two figures were generated to illustrate this difference.

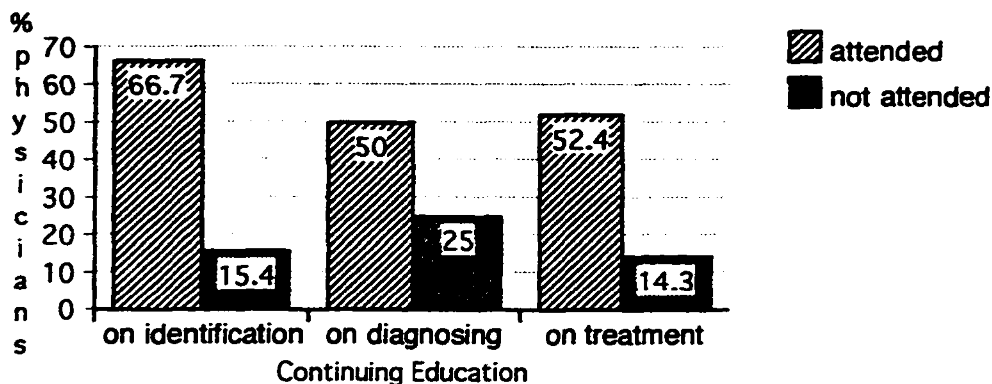

Figure 1: Percentage of Physicians who Feel Confident in Diagnosing Elderly Alcohol Abuse in Relation to their Attendance at Continuing Education

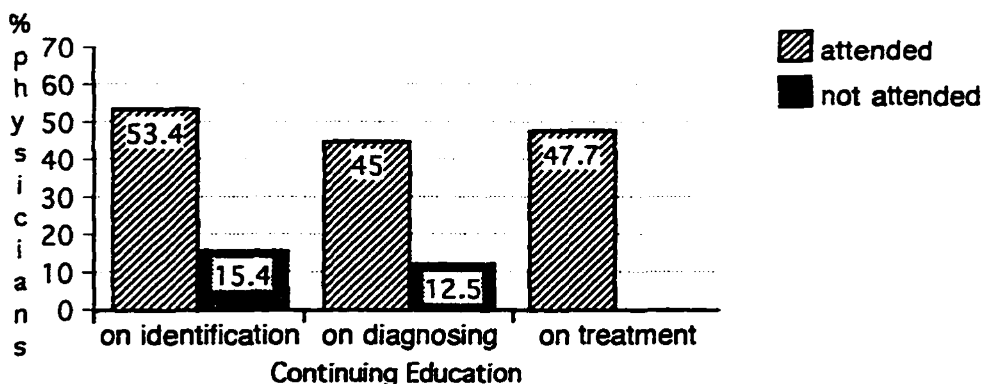

Figure 2: Percentage of Physicians who Feel Confident in Treating Elderly Alcohol Abuse in Relation to their Attendance at Continuing Education

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As shown in Figure 1 and Figure 2, physicians who attended continuing medical education on identification, diagnosis, and treatment expressed much more confidence in both, diagnosing and treating elderly alcohol abuse. These findings are confirmed when looking at physicians who estimated that elderly patients comprise more than half of their medical practice: 50 percent of them indicated that they feel confident in diagnosing, and 75 percent expressed their confidence in treating elderly alcohol abuse. Three quarters of these physicians participated in continuing medical education on diagnosing alcohol abuse, and all of them attended seminars on treating alcoholism.

These findings show that physicians' confidence in diagnosing and treating elderly alcohol abuse is strongly associated with the amount of continuing medical education they received. Physicians who expressed more confidence in diagnosing and treating elderly alcohol abuse were the ones who completed more continuing medical education, such as women and participants from the middle and the oldest age groups. In comparison, the respondents who were least likely to attend continuing education training, such as the youngest respondents and physicians who see the most patients per week, expressed less confidence.

It appears that continuing medical education is an important component in improving the confidence of physicians in diagnosing and treating elderly alcohol abuse. Since almost half of the respondents expressed great interest in addressing older patients drinking problems, building confidence in this skill could improve physicians' recognition and treatment rate of elderly alcohol abuse. The indication that continuing medical education improves

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physicians confidence in dealing with elderly alcohol abuse points to the importance of this training offered to physicians.

5.3 Identification and Treatment Rate of Elderly Alcohol Abuse in Physicians' Practices

A large part of the survey looked at physicians' subjective assessment of the prevalence, identification and treatment rate of elderly alcohol abuse in their own practices. The questions in the survey explored variables such as physicians' estimates of problem drinking among their elderly patients, routine questioning about alcohol consumption, usage of screening instruments to detect alcohol abuse among older patients, percentage of diagnosed elderly alcohol abusers referred to treatment, alcohol treatment modalities utilized by physicians, and feelings of success in helping older patients to overcome their drinking problems.

The issue of who should be primarily responsible for the identification of elderly with alcohol problems was explored. The respondents expressed mixed views regarding this question. Three quarters of physicians saw the patient's family as being the most responsible, with a third of these respondents placing a physician into second place. Three respondents believed that family physicians or health care professionals are primarily responsible, and one respondent·indicated that "responsibility is multifactorial: (1) the patient has to realize his/her alcoholism has caused problems; (2) a

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physician may identify health-related problems; (3) family". However, one respondent stated: "I am not convinced whether identification of elderly alcohol abuse is necessary".

Physicians reported that most of their older problem drinkers do not mention alcohol abuse on their own. One physician stated: "Elderly patients do not tell me that they drink too much...most of them don't even know that the quantity of alcohol they consume is too excessive". Another respondent commented: "Younger patients come in and say they have a problem, a relationship problem, a problem with their job...elderly never say that". However, those patients who bring up their excessive alcohol intake on their own are more likely to do so with physicians who received extensive training on alcohol abuse in medical school.

Despite the low number of older patients who mention alcohol abuse, physicians on average suspect 11.6 percent of the elderly in their practice have alcohol problems. Three quarters of respondents indicated the belief that anywhere from 5 to 15 percent of their elderly patients might have an alcohol abuse problem, and 10.7 percent of respondents believed that number is even higher. Again, physicians with extensive training on alcohol abuse suspected a higher percentage of elderly alcohol abuse in their practice.

Since it appears that older patients do not initiate a discussion of their own alcohol problems, physicians' questioning about alcohol consumption might be an important factor in identifying alcohol abuse. A survey done by Slama, Redman, Cockburn & Sanson-Fisher (1989) reports that most patients expect general practitioners to ask about their alcohol intake.

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Despite a relatively high suspicion rate, only 48 percent of physicians ask their older patients about drinking habits, compared to 68 percent of respondents who routinely inquire about alcohol intake of their younger patients. One physician expressed the following: "The elderly don't mention their drinking, and I don't routinely ask them...if they become very sick, then we deal with it." Physicians tend to ask older women less often than elderly men. As one respondent commented: "It is much less likely that I will ask females about their drinking habits".

Research done by Lichtenberg et al. (1993) suggests that detecting elderly alcohol abuse depends on recognizing certain symptoms which are exhibited more subtly than among younger adults. Studies show that physicians' identification of elderly alcohol abuse which is based primarily on clinical evaluation is quite low; therefore, the routine use of screening instruments is recommended in order to more accurately detect alcohol abuse in the elderly (Adams et al., 1992; Bush, Shaw, Cleary, Delbanco & Aronson, 1987; Curtis et al., 1989; Jacyk, Tabisz, Badger & Fuchs, 1991).

A number of highly effective screening questionnaires are available that can be inserted into physician's general assessments, or filled out by a patient prior to an interview. One of the most popular is the CAGE Test which is a short and easily administered questionnaire that can improve the detection rate of alcohol abuse. With its high sensitivity and specificity for identifying patients with addiction, it can be especially appropriate for use in primary care medicine (Callahan & Tierney, 1995). Another questionnaire, known for its extensive use, is the Michigan Alcoholism Screening Test or

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M.A.S.T. Although this screening instrument has been created for the general population, research data supports the use of M.A.S.T. for alcohol abuse screening in the elderly (Christensen, Willenbring, Spring & Rassmussen, 1986). A geriatric version or G-M.A.S.T. has also been developed. A more recently devised instrument is the Alcohol Use Disorders Identification Test or AUDIT which is designed to identify individuals with harmful or hazardous alcohol consumption levels well before physical dependence or chronic physical or psychological damage is manifested (Saunders & Conigrave, 1990). AUDIT can be used alone as an undisguised questionnaire or incorporated into a broader health risk factors screening instrument (see Appendices F, G, H, I for the copies of these questionnaires).

Although research indicates that incorporation of easily administered screening tools to detect dependency would improve care of the elderly patients (Jacyk et al., 1991), only 21 percent of physicians in this study use screening instruments as part of their assessment. Half of respondents stated they are familiar with them, and 62 percent indicated that appropriate materials to assess elderly with alcohol problems are not available to them.

The screening instruments are much more likely used by respondents who are confident in diagnosing alcohol abuse, and by those physicians who suspect higher rates of elderly alcohol abuse in their practice. These are also the physicians who received more training on alcohol abuse.

Physicians were asked to assess what percentage of their older patients, diagnosed with alcoholism, are referred to treatment. The results indicate that 43 percent of the respondents do not refer any of their elderly

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patients to an addiction treatment, and only 11 percent refer every diagnosed older patient. Bivariate analysis of data indicates that physicians who do not refer were less likely to receive training on alcohol abuse in medical school or to attend continuing medical education seminars, and they were less likely to use screening questionnaires for assessing drinking behaviour.

Physicians who do refer to treatment utilize several different treatment programs available in Thunder Bay for their patients diagnosed with alcohol abuse problems.

Table 2: Treatment Programs Used by Physicians who Refer Elderly Alcoholics

Treatment Modality	% of Physicians who Cited Treating Modality
Sister Margaret Smith Centre	75.0
Alcoholics Anonymous	62.5
Treat Themselves	50.0
Social Worker	12.5

As Table 2 shows, most physicians refer to the Sister Margaret Smith Centre, and about half of the respondents also engage themselves in intervention and treatment of elderly patients with alcohol problems. Some of the reasons cited for their involvement are the following:

"It is a chronic disease requiring physical and psychological treatment."
"Patients accept intervention better; less threatening than agency."
"Part of my comprehensive care."
"To improve quality of life."
"Obvious need."
"Interest; concern from alcohol: health/emotional problems."

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The types of interventions that physicians engage in with elderly alcoholics vary from office education, counselling, supportive psychotherapy, treatment of anxiety and depression, supervision of physical changes, to discussions with family members and caregivers.

Physicians were asked to state their opinions about the effectiveness of alcohol treatment programs for the elderly. Most of them expressed doubtfulness about success in treating elderly alcohol abuse. Some of the comments on the topic are the following:

> "Ineffective as most patients will not attend or admit to the problem."
> "They don't want to go to AA or to any treatment facility."
> "Less effective because they are more set in their ways."
> "Hard to get them into the program, and often targeted at younger age."
> "Not as effective as younger as they have less reason to change: 'life is over', 'what else is there for me'."
> "Probably less effective than programs for younger age groups; physicians are generally less concerned about this problem in the elderly although it can contribute to morbidity and mortality rates; alcoholism in the elderly would be ingrained and difficult to treat."

When asked how they perceive the existing treatment programs for the elderly in Thunder Bay, most respondents saw the programs as poor or inadequate. Typical comments received from physicians about treatment programs were the following: "Not great or inviting for the elderly...seniors not prioritized...not designed for the elderly." One physician stated that the treatment programs in Thunder Bay are "not very effective; seem to be focused more on the younger patients and not dealing with the psycho-social issues of the elderly." Only three respondents indicated that treatment programs for the elderly in Thunder Bay are good.

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Physicians were asked whether they wish there would be other services available in Thunder Bay for elderly with alcohol problems. Three quarters of them responded affirmatively, indicating the need for more programs designed specifically for the elderly. One respondent stated: "Personally, out-patient programs may be more effective; Smith Clinic too intimidating for most; too much stigma associated with it." Several respondents indicated a need for community oriented programs, or "specific programs to address their needs, re: isolation, depression, etc." As one physician recounted, there "needs to be more community service for these patients to investigate their present psycho-social situation which may be contributing to their alcoholism."

In general, physicians do not feel very successful in helping their elderly patients who are experiencing alcohol abuse problems. On a scale of 1 to 5, with 1 feeling not successful and 5 feeling very successful, almost half of respondents chose number 1 or 2, and only 7.1 percent picked number 4 or 5. As shown in Table 3, physicians who refer their elderly alcoholics to treatment programs are more likely to feel successful.

Table 3: Percentage of Physicians Feeling Successful in Helping Elderly Patients with Alcohol Problems in Relation to Referral Rate

Referral Rate	% of Physicians Feeling Successful
0 % of diagnosed patients referred to treatment	0.0
1-25 % of diagnosed patients referred to treatment	8.3
26+ % of diagnosed patients referred to treatment	25.0

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Bivariate analysis of collected data indicates that women feel less successful than men, and physicians who suspected a higher percentage of elderly alcohol abuse in their practice feel the least successful. It appears that training on alcohol abuse in medical school does not play a role in respondents' feelings of success. However, physicians who attended continuing education training feel more successful in helping their elderly patients to overcome alcohol-related problems.

5.4 Physicians' Attitudes toward Elderly Alcohol Abuse

An important part of the survey was the examination of physicians' attitudes toward elderly alcohol abuse. For this purpose, respondents were asked to indicate whether they agree or disagree with thirteen statements, which were designed to seek their opinions on elderly and alcohol abuse. These statements deal with topics such as identification of elderly with drinking problems, perception of an elderly alcoholic, and feelings about treating older patients with alcohol abuse problems.

The results of these statements are presented in Table 4. Following the table, a detailed description of the findings is presented, looking at the relationship between physicians' responses and different variables such as gender, age, training on alcohol abuse, number of patients seen per week, percentage of elderly in the practice, and usage of a screening questionnaire for assessing drinking behaviour.

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Table 4: Physicians' Attitudes toward Identification, Diagnosis and Treatment of Elderly Alcohol Abuse

Attitude Statement (n=28)	% Agree
1. I find it difficult to identify drinking problems among the elderly.	70.4
2. It is common to attribute alcohol-related health problems to age-related health problems.	71.4
3. It is common to focus the attention on the physical complications of alcoholism rather than the drinking itself.	71.4
4. It is common to focus the attention on the psychological complications of alcoholism rather than the drinking itself.	60.7
5. An elderly problem drinker should be allowed to enjoy his/her drinks as much as he/she wants.	21.4
6. Alcohol abuse is not a significant problem among the elderly.	10.7
7. Elderly alcoholics are uncooperative and difficult patients.	39.3
8. There is better treatment outcome for younger male alcoholics than older ones.	51.9
9. There is better treatment outcome for younger female alcoholics than older ones.	50.0
10. I am more discreet with the elderly patients when I question them about the alcohol consumption.	35.7
11. I am more confrontative and aggressive with the younger problem drinkers than the elderly ones.	42.9
12. It is more likely that I will treat or refer a younger alcoholic for an addiction treatment than an elderly one.	75.0
13. It is less important to intervene with the alcohol abuse of the elderly patients than the younger ones.	28.6

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As shown in Table 4, 70.4 percent of respondents find it difficult to identify a drinking problem in the elderly patient. Several physicians expressed the following opinions about the identification of the elderly with drinking problems:

> "The only way that I find out if the patient has an alcohol problem is when his/her family tells me... or if their health is severely compromised."
> "They are very set in their ways...they have been drinking for ever and they have their denying pattern well established."
> "Patients are not truthful with me...it's very hard to identify alcohol addiction."
> "Many times I go backwards: after the medical tests show some problem in their bodies, like liver, I would probe them and then they say they drink."
> "Older alcoholics are not as readily identified as are those who are younger - the latter get into more problems with the law and sustain more injuries as a result of reckless and anti-social behaviour."

The findings indicate that physicians who see the most patients per week are almost twice as likely to have difficulty in identifying elderly alcohol abuse than respondents who see less than 100 patients per week.

Almost three quarters of respondents stated that it is common to attribute alcohol-related health problems to age-related health problems. The physicians who have less elderly patients in their practice, and those who do not use screening questionnaires to detect alcohol abuse are more likely to attribute alcohol-related health problems to age-related health problems.

It appears that the majority of respondents tend to focus on physical and psychological complications of alcoholism rather than on the drinking itself. This is especially true with physicians who did not attend continuing

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medical education on identification and diagnosis of alcohol abuse.

Out of 28 physicians, six respondents agreed with the statement that an elderly problem drinker should be allowed to enjoy his/her drinks as much as he/she wants. Three of these respondents expressed the following:

> "They have been living for a long time...they are old. Why not letting them have their drinks."
>
> "They shouldn't drink if they have severe problems...for example, falling down, can't take care of themselves...otherwise, who am I to tell them that they can't drink."
>
> "I am not going to tell them to stop drinking...they are enjoying their drinks too much. If their blood pressure is too high, I'll tell them to watch out and slow down on their drinking...but other than that, let them drink...they are not harming anyone."

Only 10.7 percent of physicians agreed with the statement that alcohol abuse is not a significant problem among the elderly. It appears that physicians who see the most patients per week, and those who do not refer diagnosed elderly alcoholics to treatment program are more likely to agree with the statement.

Almost 40 percent of respondents indicated that elderly alcoholics are uncooperative and difficult patients. Physicians whose practices are comprised with more than 50 percent of older patients are much less likely to perceive elderly alcoholics as uncooperative or difficult patients.

Out of 21 physicians who returned the supplementary questionnaire, 13 indicated that an elderly individual with alcohol-related problems shows poor cooperation and compliance with medical treatment. 12 physicians stated that the elderly with alcohol-related problems create difficulties for them, such as

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"increase of co-morbid conditions", "associated medical problems", "poor health, poor nutrition", and "social problem concerns which I receive calls from family". One physician commented that he is "uncertain of best method to intervene", and another respondent expressed a dilemma regarding "ethic of change versus right to live as choosing".

Half of the physicians believe there is better treatment outcome for younger alcoholics than older ones, although the literature indicates that older problem drinkers respond as well as or better to treatment than younger alcoholics (Atkinson, 1987; Evans et al., 1996; McKim & Mishara, 1987; Philion, 1988). Physicians who indicated their belief that younger alcoholics have better treatment outcomes are less likely to refer diagnosed elderly alcoholics, and they less likely received training on alcohol abuse in medical school or attended continuing medical education on this topic.

Over a third of the respondents stated they are more discreet with the elderly patients when they question them about alcohol consumption. One physicians recounted: "I will be honest with you. No, I don't ask them the way I ask younger patients. I should, but I don't". Respondents who indicated that they are more discreet in questioning the elderly about their alcohol intake tend to have less older patients in their practice, they see larger number of patients per week, and they do not suspect a high number of the elderly in their practice have alcohol problems.

Of all the respondents, 42.9 percent indicated they are more confrontative and aggressive with younger problem drinkers, and three quarters of the physicians suggested that it is more likely they will treat or refer

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to an addiction treatment a younger alcoholic than an older one. One physician stated: "For many elderly the alcohol is a way of life, something which helps them escape drudgeries of old age. As long as it does not interfere with their health, I tend to leave it alone." Another physician commented: "When they don't want to do anything about their problem, I give up and don't bother them anymore about their drinking." The respondents who suspect higher percentage of elderly alcohol abuse in their practice, those who attended continuing medical education on identification and diagnosis of alcohol abuse, and those physicians whose practices are comprised with more than 50 percent of older patients are more likely to be confrontative with their older alcoholics.

The last statement, examining physicians' attitudes toward elderly alcohol abuse, is asking the respondents to agree or disagree with the assertion that it is less important to intervene with the alcohol abuse of the elderly patients than the younger ones. 28.6 percent of respondents indicated their agreement. One physician commented: "I know that it is important to intervene with the alcohol abuse of the elderly patients, but somehow I still don't do it." The physicians, disagreeing with the above assertion, are more likely the ones who received training on alcohol abuse in medical school or attended continuing medical education on the topic.

The above descriptions of the findings indicate the relationship between physicians' attitudes toward identification, diagnosis and treatment of elderly alcohol abuse, and variables such as training on alcohol abuse, number of patients seen per week, percentage of elderly in the practice, and

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usage of screening questionnaires. It appears that gender and age of the physicians also play a role in the attitudes toward elderly alcohol abuse.

Male respondents are almost twice as likely to find it difficult identifying a drinking problem in the older patient than female respondents, they are more likely to indicate that elderly alcoholics are uncooperative and difficult patients, and they are more willing to agree that alcohol abuse is not a problem among the elderly. They are also more inclined to treat or refer a younger alcoholic to an addiction treatment than an elderly one.

The results also show differences between the three age groups in attitudes toward elderly alcohol abuse. All of the respondents comprising the youngest age group believe that alcohol abuse is a problem among the elderly, and none of them feel that elderly problem drinkers should be allowed to drink as much as they want. In comparison, the majority of the participants from the middle and the oldest age groups find it difficult to identify elderly alcohol abuse, and they are more likely to refer a younger alcoholic to an addiction treatment, believing that it is less important to intervene with elderly alcoholics.

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Chapter Six

DISCUSSION

Because this study's sample was relatively small and confined to Thunder Bay, it can not be assumed that the findings accurately reflect the perceptions about elderly alcohol abuse of all primary care physicians. Some interesting and noteworthy findings from this data, however, do indicate prevailing tendency and general direction which can form a base for further research in this area. The main trends found in the study are discussed in this chapter.

The results from the collected data show that most respondents recognize that alcohol abuse is a problem among the older population. Physicians on average suspect 11.6 percent of the elderly in their practice have alcohol problems. This number is very much in accordance with other studies which have examined alcohol abuse among the elderly as shown in Chapter Three. A majority of the respondents also acknowledge the responsibility of the primary care physicians in detection of elderly alcohol abuse. Besides the patient's family, they see themselves as being the most responsible for the identification of elderly with alcohol problems.

Respondents see an elderly patient quite often: the physicians estimated that on average 41 percent of the patients seen in a given week are 65 years of age or older, and over half of respondents stated that on average

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an elderly patient visits them every three months. These frequent encounters can serve as an ideal opportunity for physicians to explore the drinking habits of the older population. Acquiring knowledge about older patients' drinking pattern during routine visits may substantially increase the identification rate by physicians. Nevertheless, it appears that physicians have a hard time identifying elderly alcohol abuse since 70 percent of the study sample indicated that they find it difficult to identify a drinking problem in elderly patients. Over 70 percent of respondents stated that it is common to attribute alcohol-related problems to age-related problems. The majority of physicians also believe that attention is frequently focused on physical or psychological complications of alcoholism rather than the drinking itself. These findings are disturbing since research shows that early detection and subsequent treatment of alcohol abuse may substantially reduce alcohol-related morbidity and mortality (Cyr & Wartman, 1988).

It seems there are several factors which might contribute to difficulties in identifying elderly alcohol abuse. First of all, physicians tend to be more discreet and less confrontative with their elderly patients when they question them about their alcohol consumption. Secondly, less than half of the respondents indicated that they routinely ask their older patients about drinking habits, although they recognize that elderly patients in general do not mention alcohol consumption on their own.

The third factor, contributing to difficulties in identifying elderly alcohol abuse, is a failure to incorporate screening instruments designed to diagnose alcohol abuse into physicians' general assessments. Only 21 percent of

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respondents use any screening questionnaires although numerous studies, referred to in this thesis, recommend their usage to more accurately detect alcohol abuse in the elderly. The fourth factor seems to be physicians' lack of time. Respondents who see over 150 patients per week are more likely to acknowledge difficulties with identification of elderly alcohol abuse.

The examination of the data indicates that even when physicians diagnose alcohol abuse problems, they may choose not to intervene. Three quarters of the respondents indicated that it is more likely they will treat or refer a younger alcoholic for addiction treatment than an elderly one, and 43 percent of physicians stated that they do not refer any of their older diagnosed alcoholic to treatment programs.

As shown in Figure 3, the study found six main characteristics of physicians who do refer their older patients to treatment programs. The two very strong traits are the training on alcohol abuse received in medical school, and the attendance in continuing medical education seminars addressing alcohol abuse. There are also two other characteristics present: usage of screening questionnaires, and confidence in diagnosing alcohol abuse. It is likely that these last two characteristics stem from respondents' knowledge about alcohol abuse obtained through their training. Physicians who refer their older patients to treatment are also more likely to feel successful in helping elderly with alcohol abuse problems, and they are more likely to perceive elderly alcohol abuse treatment as effective.

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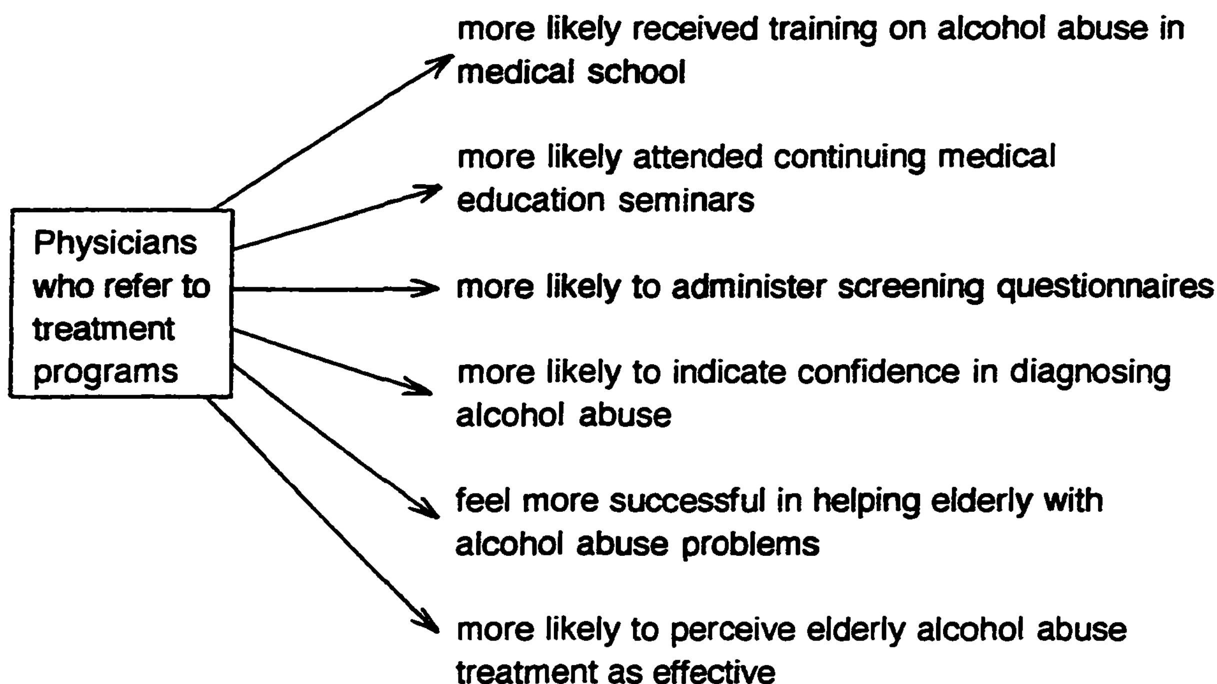

Figure 3: Profile of Physicians who Refer their Diagnosed Elderly Alcoholics to Treatment Programs

The examination of the collected data shows several underlying causes for poor intervention and treatment rate of elderly alcohol abuse. It appears that physicians least likely to identify, and subsequently refer their elderly patients to alcohol treatment, are the ones who received no training on alcohol abuse in medical school. They are also less likely to attend continuing medical education seminars on alcohol abuse, and they tend to perceive the treatment of elderly alcoholics as not effective.

In addition to the insufficient training on alcohol abuse, findings from the collected data show that physicians' attitudes toward elderly alcohol abuse may also contribute to the low identification and treatment rates of elderly alcoholics. Almost 40 percent of physicians stated that elderly alcoholics are

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uncooperative and difficult patients, and 21.4 percent of respondents expressed the belief that an elderly problem drinker should be allowed to enjoy his/her drinks as much as he/she wants. Almost half of physicians indicated that they are more confrontative and aggressive with the younger problem drinkers than the elderly ones, and 28.6 percent stated that it is less important to intervene with alcohol abuse of the elderly patients. Respondents' comments, such as "they are very set in their ways... a way of life...they are enjoying their drinks too much...their denying pattern is well established...less reason to change...they are old...let them drink...helps them escape drudgeries of old age" show some physicians' beliefs that the elderly are too embedded in their denial, and too old to change. Such negative attitudes point towards ageist assumptions which can lead into detection and treatment avoidance, and thus reducing the value of older patients' lives.

Looking at the collected data, it appears that most physicians see elderly with alcohol problems as aging alcoholics, or the early-onset alcohol abusers, although studies referred to in Chapter Three suggest that one third of the elderly alcoholics can be classified as geriatric or late-onset problem drinkers. Many physicians who intervene with alcohol abuse of their older patients restrict their involvement to the maintenance and control of health problems; none of the respondents indicated that they search for causes of excessive drinking, such as emotional or social factors, and subsequently offer or suggest appropriate help and solutions. It is important to recognize that elderly alcoholics, like the older population overall, are a heterogeneous group in relation to the range of experiences, diversity in their drinking habits,

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and underlying causes of their drinking problems. Individualized attention to the older patient is an essential component in the comprehensive care for the geriatric population.

The examination of the collected data also shows another reason that a large percentage of respondents are not referring their elderly patients to treatment. It appears that the lack of appropriate programs available in Thunder Bay is playing a significant role in treatment rates. Physicians overwhelmingly stated that current treatment programs are inadequate or poorly designed for the older patients. They expressed a need and a desire for a community-based approach to treatment, with programs specifically designed for the elderly and their needs. The question arises whether respondents' non-referring pattern stems from their work experiences and perceptions of the existing treatment programs in Thunder Bay.

This study was designed to seek the answer to the question: What is the cause for the low recognition and treatment rate of elderly alcohol abuse by primary care physicians? The above discussion of the findings shows that the cause is multifactorial, with many of the factors being interrelated. The identified factors are:

- lack of training on alcohol abuse in medical schools;
- low attendance at continuing medical education seminars on alcohol abuse;
- negative attitudes toward elderly alcohol abuse;
- lack of time/large patient load;
- existing treatment programs perceived as non-effective.

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Most of these identified factors seem to be related to each other. Looking at the findings, it appears that the lack of training on alcohol abuse in medical schools strongly influences the respondents' attitudes toward elderly alcohol abuse, which in turn can contribute to the low recognition and treatment rate. The same conclusion can be made when examining the participation at continuing medical education seminars on alcohol abuse. There is also a relationship between large patient load and low attendance at continuing medical education seminars on alcohol abuse since the findings indicate that respondents who see the most patients per week are the least likely to attend such seminars. Physicians with the large patient load also do not perceive alcohol abuse as a problem among their older patients. The only identified factor that seems unrelated to others is the respondents' perception of existing treatment programs in Thunder Bay as non-effective. This perception was found in 75 percent of participants, regardless of the amount of training on alcohol abuse they received or the number of patients they see in a week.

Of the above identified factors, physicians' training on alcohol abuse appears to be a very strong determinant for recognition and treatment of elderly alcohol abuse. Figure 4 and Figure 5 were created to graphically demonstrate the profile of the respondents who received alcohol abuse training in medical school, and who attended continuing medical education seminars on this topic. The intent was to illustrate the characteristics of those respondents who received training on alcohol abuse.

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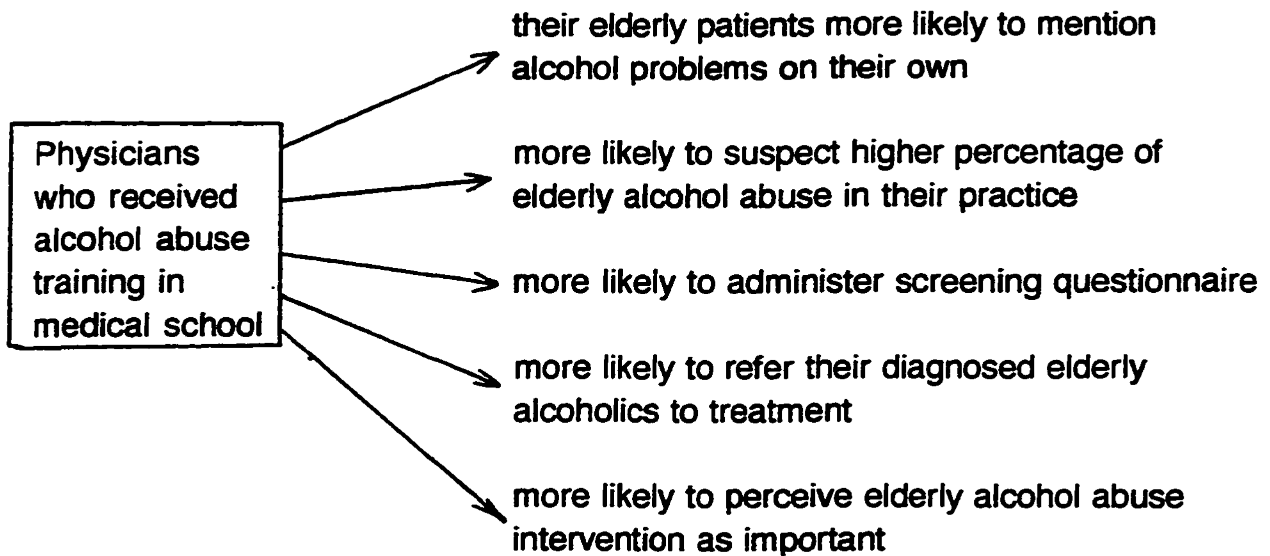

Figure 4: Profile of Physicians who Received Training on Alcohol Abuse in Medical School

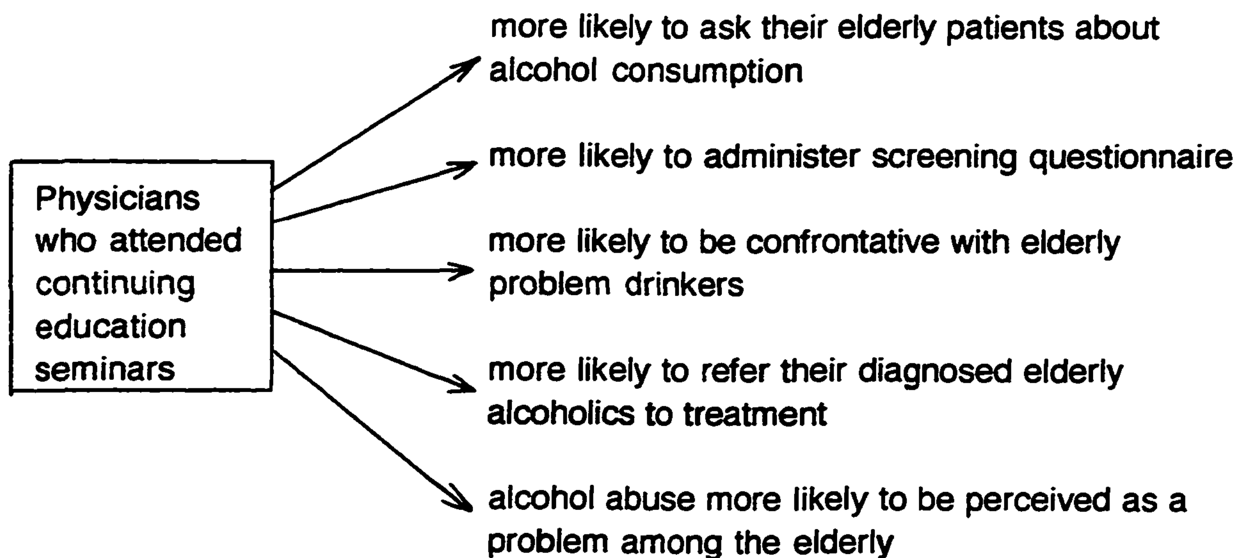

Figure 5: Profile of Physicians who Attended Continuing Medical Education Seminars on Alcohol Abuse

As seen in the above two figures, physicians' training on alcohol abuse is a very noteworthy variable, determining the characteristics which have been

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shown to play an important role in identifying and/or referring diagnosed elderly alcoholics to treatment.

The conclusion that training is a very strong determinant for recognition and treatment of elderly alcohol abuse can be connected to professional socialization which is used as a conceptual framework for this thesis. As stated in Chapter Two, individuals are professionally socialized to function in a role of physician through formal and informal learning. The formal educational program introduces the skills necessary for the technical practice of medicine, and the informal process provides physicians with particular attitudes towards themselves, their work, and their patients (Kurtz & Chalfant, 1984). Professional socialization teaches values, along with technical components of medicine (Conrad, 1988). The perspectives that physicians acquire through professional socialization permeate their consciousness, forming a specific lens for viewing the world (ibid.). It can be stated that physicians' perceptions of elderly alcohol abuse stems from professional socialization since physicians' knowledge of alcohol abuse and their attitudes toward the older population are based in socialization of the medical profession.

Alcohol abuse training, either through medical schools or continuing medical education seminars, appears to be an important factor in the socialization of physicians and will determine their identification and treatment rate of elderly alcohol abuse. When such education is not present, physicians are less likely to suspect elderly alcohol abuse in their practice, and they are less likely to ask elderly patients about their drinking habits or to administer screening questionnaires. They are more likely to perceive treatment of elderly

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alcoholism as not effective which may contribute to a lower referral rate to treatment programs.

Physicians' training is also connected to their attitudes toward elderly alcohol abuse. Respondents with less training are more likely to express negative attitudes and ageist assumptions when questioned about their perceptions of an elderly alcoholic. They are more likely to believe that alcohol abuse is not a problem among the elderly, and that elderly problem drinkers should be allowed to drink as much as they want. These respondents also stated that it is less important to intervene with alcohol abuse of the elderly patients than the younger ones.

As stated in Chapter Two, not only the training but also the situational factors within the immediate work environment can shape physicians' professional socialization and influence their current attitudes and perspectives. The environment of respondents' practice settings, such as a lack of appropriate treatment programs for the elderly in Thunder Bay or participants' large patient load, are also found to be the factors in shaping respondents' attitudes and contributing to the low recognition and treatment rate of elderly alcohol abuse.

In conclusion, it can be conceptualized that how physicians perceive, and subsequently deal with elderly alcohol abuse stems from the professional socialization which occurred during their medical education, through their work environment, or both. As an illustration, Figure 6 was created to graphically demonstrate the professional socialization model as applied to this study of physicians' perceptions of elderly alcohol abuse.

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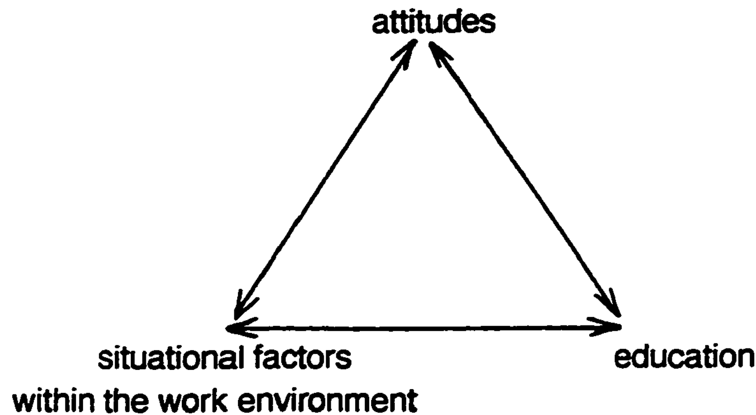

Figure 6: Illustration of the Professional Socialization Model as Applied to Physicians' Perceptions of Elderly Alcohol Abuse

As shown in the above figure, the components of the triangle, representing the professional socialization model as applied to physicians' perceptions of elderly alcohol abuse, are: education, constituting of the training in medical school and the attendance at the continuing medical education seminars; situational factors within the work environment; and attitudes toward elderly alcohol abuse. All three elements appear very much connected, influencing each other.

The education component affects respondents' attitudes toward alcohol abuse and the older population, which in turn can have an effect on physicians' situational factors in their work environment. This research shows that respondents' training determines the characteristics, such as skills and attitudes, which can play an important role in identifying and referring elderly alcoholics to treatment.

At the same time, the situational factors can also influence physicians' attitudes and education. For example, a large patient load seems to play part in

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respondents' lack of attendance at the continuing medical education seminars. Also, the perception of the existing treatment programs in Thunder Bay as inadequate or ineffective for the elderly can affect respondents' attitudes toward elderly alcohol abuse treatment, and thus influencing the referral rate.

This professional socialization model as applied to respondents' perceptions of elderly alcohol abuse suggests that any recommendations to improve primary care physicians' identification and treatment rate of elderly alcohol abuse should take into the account all three identified components: education, situational factors of physicians' work environment, and attitudes toward elderly and alcohol abuse. Looking only at one component may not accomplish desired results, providing only partial or superficial solution.

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Chapter Seven

CONCLUSIONS

7.1 Practical Implications and Recommendations

With a growing proportion of the population being in the older age group, we have to be able to identify and find the solutions for the problems of this population. Elderly alcohol abuse is seen as one of these problems although it is often unrecognized and hidden among seniors. Nevertheless, it does exist and it can claim a very high medical and social toll not only for the aged but also for the community as a whole. Therefore, it is imperative to identify and treat older alcoholics in an attempt to lessen the person's burden of unnecessary illness, increase his/her quality of life, and diminish health care needs.

This research can be seen as an exploratory study searching for the causes of low recognition and treatment rate of elderly alcohol abuse by primary care physicians. Examination of the data points to several practical implications and recommendations which may help diminish this problem. As stated in Chapter Six, we have to consider all the identified components of physicians' perceptions of elderly alcohol abuse if we want to achieve intended outcomes. Therefore, the practical implications and recommendations of this study are exploring the areas of physicians'

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education, situational factors of their work experience, and their attitudes toward the elderly and alcohol abuse.

The research shows that medical schools offer little training on alcoholism to their students. One clear implication of this study is that physicians need more training in medical school, and they need to be given the message that interventions in drinking problem situations can be helpful to elderly patients. Moore et al. (1989) point out in their study that even a minimal effort on the part of the physician in instructing the patient and arranging treatment can translate into a positive impact in motivating the patient to follow the recommendations.

This study unequivocally confirms that alcohol abuse training in medical school improves primary care physicians' recognition and treatment rate of elderly alcohol abuse. The Canadian Medical Association itself recognized the importance of medical training on alcohol abuse by publishing a policy summary which recommended that all Canadian medical schools establish appropriate education programs (Canadian Medical Association, 1993). At the same time, medical schools should increase students' positive contacts and first-hand experiences with a variety of elderly individuals within the curriculum. This approach may prevent the development of ageist assumptions and dispel stereotypes about the older population.

A significant implication coming from this study is the importance of continuing medical education for primary care physicians. The local medical association should continue offering seminars on alcohol abuse, with special focus on the older population. During these seminars, findings from recent

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studies should be introduced such as prevalence of elderly alcohol abuse, usage of screening questionnaires, and success rate of treatment programs designed for the elderly. By expanding physicians' knowledge of elderly alcohol abuse, the confidence in identifying and diagnosing this problem will increase, leading to higher treatment rate. Primary care physicians also have to recognize that the elderly are not a homogeneous group, and neither are elderly alcoholics. The recognition of the difference between early and late-onset of alcohol abuse may lead to appropriate suggestions and recommendations of help.

Physicians need to become aware of their attitudes toward elderly patients with alcohol problems to allow themselves to work objectively. By recognizing the existence of negative attitudes, physicians can provide the same quality of care they offer to younger alcoholics.

The literature review indicates that elderly alcohol abuse is hidden and hard to identify. Detecting it depends on recognizing certain symptoms which are exhibited more subtly than among younger adults (Lichtenberg et al., 1993). The routine use of screening instruments can lead to more accurate detection of alcohol abuse in the elderly. This study identified a lack of physicians' knowledge regarding screening questionnaires and a lack of these materials available to them. A recommendation of this research is to acquaint physicians about screening tools, and to provide the questionnaires to them. This could be accomplished by Thunder Bay Medical Society or by appropriate social service agencies.

Another practical implication of this study is the need for elder-specific

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treatment programs. The existing services in Thunder Bay are perceived by physicians as not effective for the older population. The community needs to establish programs which would be designed specifically for the elderly, addressing their needs. Informing the physicians about any such programs would be essential. Communications could take place through information sessions, literature, or by continuing medical education seminars which the Thunder Bay Medical Society organizes frequently.

Lastly, this research also has implications for the community at large. Not only health professionals but also the general public need to be informed about the harm of elderly alcohol abuse. Families and caregivers need to be aware that by protecting the elderly and discounting their drinking, they may be ignoring the seriousness of the situation. Better awareness of the problem could decrease the probability of unnecessary illness, alcohol-related visits to emergency rooms, alcohol-related placement in mental health or long-term care facilities, or premature death.

7.2 Suggestions for Future Research

A number of issues related to this research merit further investigation. It would be very beneficial to include more primary care physicians in the study. By increasing the number of respondents, the findings can be generalized beyond the participant sample.

The study could be replicated in a rural area where primary care

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physicians likely have considerable knowledge about social concerns and problems of their patients. Are physicians who are well aware of an elderly patient's social issues more likely to identify and intervene with alcohol problems than their colleagues in an urban area?

The study could also be replicated in a community where treatment programs designed specifically for elderly alcoholics are available. Are the physicians' attitudes toward the treatment of elderly alcoholics in that community the same as the ones found in this study? Does the availability of treatment improve physicians' perceptions of such programs, and increase their referral rate?

Physicians' attitudes toward elderly with alcohol abuse problems could be compared with attitudes toward elderly with other types of illnesses. Is it just alcohol abuse that physicians are less likely to treat, or are there other illnesses that the treatment rate may depend on the age of the patient?

It would also be helpful to compare physicians' perceptions of elderly alcohol abuse with the perceptions of other health professionals, especially nurses. Do nurses express more interest and concern for elderly alcoholics than physicians?

Clearly, the potential for research in this area is great. Although the investigation of physicians is difficult due to their busy schedules, large workload and their reluctance to participate, the knowledge which could be obtained is worth the effort. The problem of elderly alcohol abuse will not go away, and the potential benefits of research are too great to ignore.

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7.3 Conclusion

As shown in this study, low identification and treatment rate of elderly alcohol abuse by primary care physicians is a concern. The literature shows us that alcohol abuse does not exist only among the younger population, but also among the elderly individuals. The older population can be highly vulnerable to the effects of alcohol due to the decreased lean body mass, changes in metabolism and increased sensitivity to the effects of alcohol. Many obstacles in identifying elderly alcohol abuse may prevent the usual recognition of alcohol problems which underlines the importance of physicians' role in discovering and identifying elderly alcohol abuse. Although treatment of elderly alcoholics can be quite successful, many physicians are not enthusiastically or effectively diagnosing, and subsequently treating, alcohol abuse among the elderly.

It is hoped that this study has illuminated some aspects of the problem of low identification and treatment rate of elderly alcohol abuse by primary care physicians. The knowledge gained from this study may contribute to research and literature in the field of elderly alcohol abuse, or serve as a building block for additional research in this area. I believe that the study revealed some of the underlying causes of low identification and treatment rate by primary care physicians in Thunder Bay. Hopefully, the practical implications and recommendations derived from this research will help in improvement of this problem.

In conclusion, there are several impressions and thoughts about the

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study that I would like to share. I found this research difficult to conduct due to several obstacles. It was very hard to recruit the physicians to participate in the study. Often, it was impossible to penetrate the front line staff, such as receptionists and secretaries, to reach the physicians. Even when communication with potential participants was established, their large patient load or a lack of time prevented them to engage in the study. Also, the limited time given to me by the participants hindered any deeper exploration of the issues.

Many physicians who participated in the study expressed genuine concern about low identification and treatment rate of elderly alcohol abuse. They acknowledged that the problem exists, however, it is not often brought to discussion. A few participants were very interested in learning about the findings of this research. Although this thesis will be available at the Lakehead University library, I plan to present a copy to those physicians who specifically asked for it. My intention is also to share the results of the study with the Thunder Bay Medical Society. Hopefully, some of the practical implications and recommendations derived from this research can be presented to physicians in Thunder Bay through their future continuing medical education seminars.

After the completion of data analysis, certain areas were identified that need additional investigation. I believe that physicians' perceptions, and subsequent treatment, of early and late-onset of elderly alcoholism merits further examination. Also, looking at physicians' own attitudes about alcohol consumption may provide a new insight to the problem of low identification and

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treatment.

My intention is to continue with research in this area. Due to my previous contact with physicians, it may be easier to recruit the participants for a future study. A qualitative research design, with in-depth interviews of 8 to 10 participants may provide further information and deeper knowledge of physicians' perceptions of elderly alcohol abuse. The additional practical implications and recommendations derived from such a study may help the elderly with alcohol abuse problems, lowering the medical and social costs and improving their quality of life.

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APPENDICES

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Physician's questionnaire

1. Sex: M F

2. Age: ____ years

3. Years practicing medicine: ____ yrs.

Please, relate the following questions to the past 12 months:

4. Location practicing medicine:
   ___ office
   ___ community health clinic
   ___ hospital
   ___ chronic care hospital
   ___ nursing home
   ___ home visits

5. What is the estimated percentage of patients who are age 65 or over in your practice (all locations)? ____ %

6. What is the estimated percentage of elderly patients who are:
   female: _____ % male: _____ %
   any predominant ethnic group: ______________________________

7. On average, how many patients do you see per week? ______

8. What percentage of patients seen during a typical week are aged 65 or over? _____ %

9. On average, how often does an elderly patient come to see you?
   ___ once every 2 weeks ___ every 6 months
   ___ once a month ___ once a year
   ___ every 3 months ___ other: ______________

10. In your estimation, what percentage of elderly in your practice (all locations) mention that they use too much alcohol? _____ %

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11. What percentage of the elderly in your practice (all locations) do you suspect have an alcohol-related health problem? _____ %

12. How many of diagnosed elderly alcoholics do you refer to a treatment agency? _____ %

13. Where do you refer them?
    ___ The Smith Clinic
    ___ social worker
    ___ Alcoholics Anonymous
    ___ other physician
    ___ treat myself
    ___ other: ________________________

14. Do you provide a follow-up to the treatment? yes no

15. How successful do you feel in helping your elderly patients to overcome the alcohol-related health problem?

    1 2 3 4 5

    not successful very successful

16. Do you regularly ask your patients about their drinking behaviour? yes no

17. Do you ask elderly patients about their drinking behaviour at the same frequency as you ask younger patients?
    - males: yes no
    - females: yes no

18. Do you administer any standardized questionnaire (such as MAST or CAGE) to assess the drinking behaviour of your elderly patients?
    - males: yes no
    - females: yes no

Please, indicate whether you <u>agree</u> or <u>disagree</u> with the following statements:

19. I find it difficult to identify a drinking problem in the elderly patient: A D

20. it is common to attribute alcohol-related health problems to age-related health-problems: A D

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21. it is common to focus the attention on the physical complications of alcoholism rather than the drinking itself: A D

22. it is common to focus the attention on the psychological complications of alcoholism rather than the drinking itself: A D

23. an elderly problem drinker should be allowed to enjoy his/her drinks as much as he/she wants: A D

24. alcohol abuse is not a significant problem among the elderly: A D

25. elderly alcoholics are uncooperative and difficult patients: A D

26. there is better treatment outcome for younger male alcoholics than older ones: A D

27. there is better treatment outcome for younger female alcoholics than older ones: A D

28. I am more discreet with the elderly patients when I question them about the alcohol consumption: A D

29. I am more confrontative and aggressive with the younger problem drinkers than the elderly ones: A D

30. it is more likely that I will treat, or refer a younger alcoholic for an addiction treatment, than an elderly one: A D

31. it is less important to intervene with the alcohol abuse of the elderly patients than the younger ones: A D

Please, assess to the best of your ability:

32. How much training on alcohol abuse and treatment did you receive in medical school?

___ none at all
___ minimal
___ extensive

1 2 3 4 5
none at all extensive

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33. Did you ever take a continuing medical education course addressing:
   - the identification of alcohol abuse? yes no
   - the diagnosing of alcohol abuse? yes no
   - the treatment of alcohol abuse? yes no

34. How confident do you feel in:
   - diagnosing elderly alcohol addiction?

     1 2 3 4 5
     not confident very confident

   - treating elderly alcohol addiction?

     1 2 3 4 5
     not confident very confident

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PHYSICIANS' PERCEPTIONS OF ELDERLY ALCOHOL ABUSE

- Supplementary questionnaire -

1. Sex: M F

2. Age: ____ years

3. Years practicing medicine: ____ yrs.

4. Location practicing medicine: (please, check all that apply)
   ___ office
   ___ community health clinic
   ___ hospital
   ___ chronic care hospital
   ___ nursing home
   ___ home visits

5. Estimated percentage of patients who are age 65 or over in your practice (all locations): ____ %

Please, take a few minutes to express freely your comments on the following questions about elderly alcohol abuse. Your opinions are very valuable and important to gain more knowledge on this topic.

6. What is your opinion about the effectiveness of alcohol treatment programs for the elderly?

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7. How would you assess alcohol treatment outcomes of elderly?
(please, circle one number)

1	2	3	4	5
very poor				very good

8. How do you perceive the existing alcohol treatment programs for the elderly in Thunder Bay?

9. In your opinion, of all the existing treatment programs/services in Thunder Bay, which one is the most effective?

10. Do you wish there would be other services available in Thunder Bay for elderly with alcohol-related problems? If yes, which ones?

11. In your opinion, who is primarily responsible for the identification of elderly with alcohol-related problems?

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12. In your opinion, who is primarily responsible for the treatment of elderly with alcohol-related problems?

13. Do you regularly offer alcohol treatment to the elderly patients with alcohol-related problems?

    yes   no

14. Do you engage yourself in any intervention/treatment of elderly patients with alcohol-related problems?

    yes -------> please, go to question 15
    no -------> please, go to question 16

15. What are the reasons that you are involved in intervention/treatment?

16. What are the reasons that you are not involved in intervention/treatment?

17. What types of interventions are you willing to engage in with elderly alcoholics?

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18. What is your perception of the effectiveness of intervention/treatment by primary care physicians?

19. What is you opinion about the cooperation with medical treatment by elderly who have alcohol-related problems?

20. Do elderly with alcohol-related problems create any special difficulties for you?

    no
    yes ------> what kind? (please, elaborate)

21. What is your opinion about confronting the elderly patients with alcohol-related problems with respect to their drinking?

22. Are you familiar with objective standardized questionnaires which assess drinking behaviour?

    no
    yes ------> which ones?

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23. Are appropriate materials to assess elderly with alcohol-related problems available to you?

no yes

24. Are appropriate materials to treat elderly with alcohol-related problems available to you?

no yes

25. What is your opinion about the training on alcohol abuse and treatment you received in medical school?

26. How would you assess your knowledge about identification of elderly alcohol abuse? (please, circle one number)

1 2 3 4 5
poor excellent

27. How would you assess your knowledge about treatment of elderly alcohol abuse? (please, circle one number)

1 2 3 4 5
poor excellent

28. What is your interest in addressing older patients' drinking problems? (please, circle one number)

1 2 3 4 5
no interest great interest

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Any additional comments:

Thank you very much for your time and cooperation. Please, return this questionnaire in the envelope provided.

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THUNDER BAY MEDICAL SOCIETY RECORD OF PHYSICIANS*

Appendix C

HUGHES, DR. H. J.
Spence Clinic

HUMPHREY, DR. W.
Emergency - McKellar Hosp.

HUMPHRIES, DR. P.
Academy Clinic

HURDON, DR. V.
Thunder Bay Cancer Clinic

HUTCHINSON, DR. L.
Lakehead Psychiatric Hosp.

INOUYE, DR. S.T.
Fort William Clinic

JAWARD, DR. A.
Radiology - St. Joe's & PAGH

JOANES, DR. J.F.
Port Arthur Clinic

JOHNSON, DR. D.
Thunder Bay Medical Centre

JOHNSON, DR. P.
1103 E. Victoria Ave. P7C 1B7

JOHNSON, DR. R.
Harbour View Medical Clinic

JOWETT, DR. E. W.
Thunder Bay Medical Centre

JUVSHIK, DR. A.
124 E. Frederica St. P7E 3V5

KAJANDER, DR. R.E.
242 Hodder Ave. P7A 1S9

KALD, DR. A.L.
Port Arthur Clinic

KANE, DR. T.J.
1425 Cuthbertson Pl. P7E 5L3

KENNEDY, DR. S.
Harbour View Medical Clinic

KIM, DR. A.
Emerg. - St. Joe's.

KIRK, DR. A.
Port Arthur Clinic

KLETKE, DR. R.R.
Lakehead Psychiatric Hosp.

KOTALIK, DR. J.F.
Thunder Bay Cancer Clinic

KRAFT, DR. J. P.
Port Arthur Clinic

KRUPA, DR. N.
Fort William Clinic

KUTCHER, Dr. W.
Port Arthur Clinic

KYLE, DR. Joan
116 Summit Avenue, P7B 3P1

LAI, DR. C.C.
Curans Health Centre,
277 S. Algoma St. P7B 3C3

LAKE, DR. Chris
Emergency - P.A.G.H.

LANDRY, DR. J.L.
Radiology - McKellar

LAWSON, DR. PHIL
Emergency - McKellar

LEGGE, DR. D.
Thunder Bay Medical Centre

LEISHMAN, DR. D.
Port Arthur Clinic

LEITRANTS, DR. P.
Fort William Clinic

LEWIS, DR. John
Emerg. - McKellar Hosp.

LEY, DR. D.
Anesthesia - PAGH

*Sample of one page from T.B. Medical Society Record

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Appendix D

LAKEHEAD UNIVERSITY

er Road, Thunder Bay, Ontario, Canada P7B 5E1

Department of Sociology
Telephone: (807) 343-8477
Fax: (807) 343-8023

(date)

Dr. (name)
(address)
Thunder Bay, Ontario
(postal code)

Dear Dr. (name):

I am a graduate student in the Department of Sociology at Lakehead University writing a thesis entitled PHYSICIANS' PERCEPTION OF ELDERLY ALCOHOL ABUSE. The purpose of this study is (a) to examine the physicians' assessment of the prevalence of elderly alcohol abuse in their practice, (b) to assess the identification of elderly alcohol abuse in the practice, and (c) to evaluate the attitudes toward elderly alcohol abuse. The information gathered will provide a better understanding of identification, diagnosing and treatment of elderly alcohol abuse by physicians in Thunder Bay.

To accomplish this goal, I am asking for your voluntary participation in answering a few questions. My intent is to obtain as much information as possible about elderly alcohol abuse from the physicians' point of view. I believe that of all health service providers the primary care physicians, such as yourself, have the most contact with the elderly in our community. Therefore, your participation in this study is very important since you play a significant role in recognizing and modifying your patients' use of alcohol.

A questionnaire consisting of 34 questions has been developed. My intent is to personally present to you this questionnaire at a meeting convenient to you. It will take 10 to 15 minutes of your time to give me the answers to these questions.

cont.../2

ACHIEVEMENT THROUGH EFFORT

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I realize that you have very little spare time; therefore, I am asking you to notify your secretary of the most convenient time I can meet you. I will call her within the next week to confirm the appointment. If you prefer, you/your secretary can call me at 935-2922 anytime.

All information gathered will remain strictly confidential. No individual will be identified in any report of the results. The collected data will be retained in a locked data storage for seven years. The findings of this study will be available at Lakehead University library upon the completion of this project. If you have any questions, please contact me at the above mentioned number, or my thesis supervisor, Dr. R. Ruiperez at 343-8530.

Thank you for your cooperation.

Sincerely,

Sonja Habjan
Graduate Student, Lakehead University
Thunder Bay, Ontario
P7B 5E1
(807) 935-2922

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CONSENT FORM

My signature on this sheet indicates I agree to participate in a study by Sonja Habjan, a graduate student in the Department of Sociology at Lakehead University, on PHYSICIANS' PERCEPTION OF ELDERLY ALCOHOL ABUSE.

I have received explanations about the nature of the study and its purpose.
I understand the following:

1. I am a volunteer and can withdraw at any time from the study.
2. There is no risk of physical or psychological harm.
3. The data I provide will be confidential.
4. The collected data will be placed in data storage for seven years.
5. The findings of this study will be available at Lakehead University library upon the completion of this project.

Signature of Participant Date

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CAGE Test

1. Have you ever felt you should **C**ut-down on your drinking?

2. Are you **A**nnoyed when people criticize your drinking?

3. Have you felt bad or **G**uilty about your drinking?

4. Have you ever needed a drink in the morning as an **E**ye-opener?

** Two positive responses to CAGE indicate that the patient has experienced problems with alcohol.

Source: Bagley, G. (1997). Helping problem drinkers in your practice. Patient Care, 8 (6), 49-63.

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M.A.S.T. Questionnaire

Points		
2	*1.	Do you feel you are a normal drinker?
2	2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening before?
1	3.	Does your spouse/parents ever worry or complain about your drinking?
2	*4.	Can you stop drinking without a struggle after one or two drinks?
1	5.	Do you ever feel bad about your drinking?
2	*6.	Do friends or relatives think you are a normal drinker?
0	7.	Do you ever try to limit your drinking to certain times of the day or to certain places?
2	*8.	Are you always able to stop drinking when you want to?
5	9.	Have you ever attended a meeting of Alcoholics Anonymous?
1	10.	Have you gotten into fights when drinking?
2	11.	Has drinking ever created problems with you and your spouse?
2	12.	Has your spouse (or other family member) ever gone to anyone for help about your drinking?
2	13.	Have you ever lost friends or girl/boyfriends because of drinking?
2	14.	Have you ever gotten into trouble at work because of drinking?
2	15.	Have you ever lost a job because of drinking?
2	16.	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
1	17.	Do you ever drink before noon?
2	18.	Have you ever been told you have liver trouble? Cirrhosis?
2	19.	Have you ever had delirium tremens (DTs), severe shaking, heard voices or seen things that weren't there after heavy drinking?
5	20.	Have you ever gone to anyone for help about your drinking?
5	21.	Have you ever been in a hospital because of drinking?
2	22.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem?
2	23.	Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotional problem in which drinking had played a part?
2	24.	Heave you ever been arrested, even for a few hours, because of drunk behaviour?
2	25.	Have you ever been arrested for drunk driving or driving after drinking?

* Negative responses are alcoholic responses.

** A score of three points or less is considered nonalcoholic, a score of four points is suggested of alcoholism, and a score of five points or more indicates alcoholism.

Source: Selzer, M. L. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. American Journal of Psychiatry, 127 (12), 1653-1658.

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Appendix H

G-M.A.S.T. Questionnaire

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?
2. When talking to others, do you ever underestimate how much you actually drank?
3. Does alcohol make you sleepy so that you often fall asleep in your chair?
4. After a few drinks, have you sometimes not eaten or ben able to skip meals because you didn't feel hungry?
5. Does having a few drinks help you decrease your shakiness or tremors?
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?
7. Do you have rules for yourself that you won't drink before a certain time of the day?
8. Have you lost interest in hobbies or activities you used to enjoy?
9. When you wake up in the morning, do you ever have trouble remembering part of the night before?
10. Does having a drink help you sleep?
11. Do you hide your alcohol bottles from family members?
12. After a social gathering, have you ever felt embarrassed because you drank too much?
13. Have you ever been concerned that drinking might be harmful to your health?
14. Do you like to end an evening with a night cap?
15. Did you find your drinking increased after someone close to you died?
16. In general, would you prefer to have a few drinks at home rather than go out to social events?
17. Are you drinking more now than in the past?
18. Do you usually take a drink to relax or calm your nerves?
19. Do you drink to take your mind off your problems?
20. Have you ever increased your drinking after experiencing a loss in your life?
21. Do you sometimes drive when you have had too much to drink?
22. Has a doctor or nurse ever said they were worried or concerned about your drinking?
23. Have you ever made rules to manage your drinking?
24. When you feel lonely, does having a drink help?

** Scoring: 5 or more "yes" responses are indicative of an alcohol problem.

Source: Majcen, M. (1996). Problem drinking older adults: An examination of treatment modalities. (Master project, Lakehead University).

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AUDIT - Alcohol Use Disorders Identification Test

1. How often do you have a drink containing alcohol?

never	monthly or less	two to four times a month	two to three times a week	four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more

3. How often do you have six or more drinks on one occasion?

never	less than monthly	monthly	weekly	daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

never	less than monthly	monthly	weekly	daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

never	less than monthly	monthly	weekly	daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

never	less than monthly	monthly	weekly	daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

never	less than monthly	monthly	weekly	daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

never	less than monthly	monthly	weekly	daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

no	yes, but not in the last year	yes, during the last year

10. Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?

no	yes, but not in the last year	yes, during the last year

Source: Saunders, J. B., & Conigrave, K. M. (1990). Early identification of alcohol problems. Canadian Medical Association Journal, 143 (10), 1060-1069.

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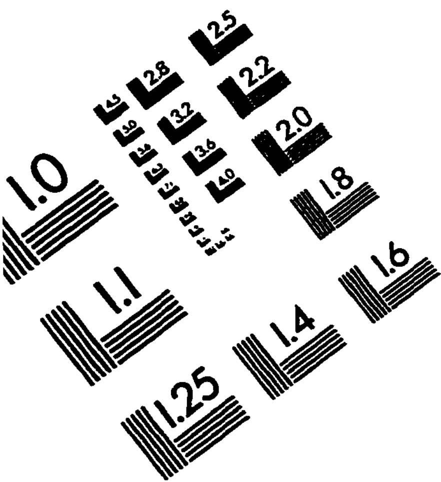
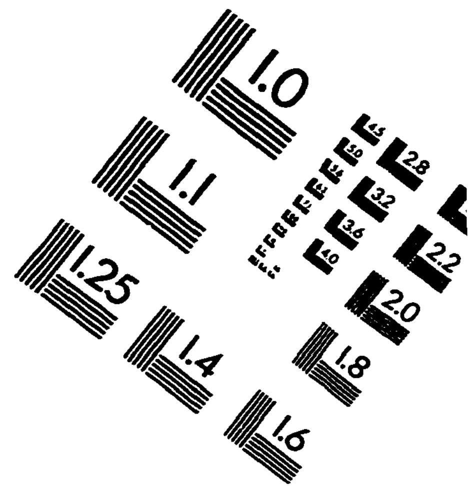
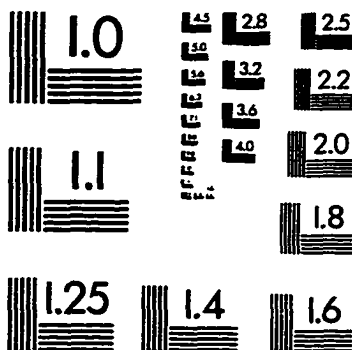
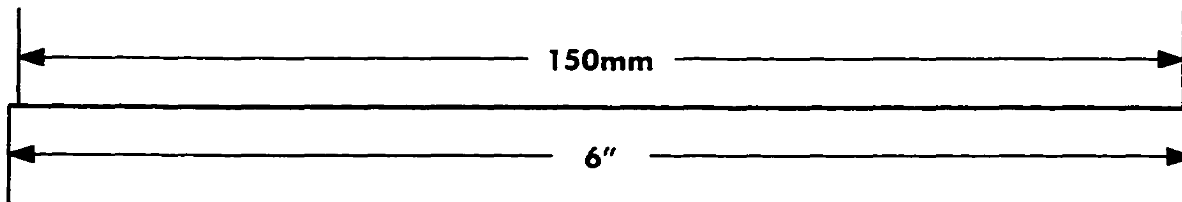
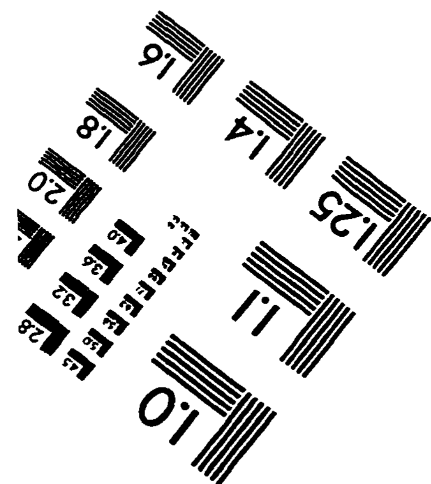
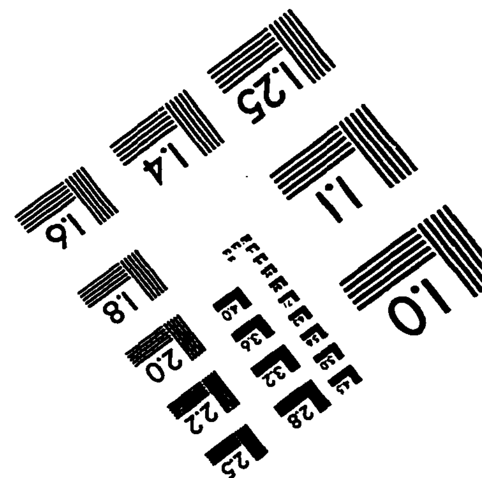
IMAGE EVALUATION TEST TARGET (QA-3)

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