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Cover Page Footnote

The author is grateful for the assistance of William M. Holmes.

Physicians' Treatment of Elderly Alcoholics *

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ABSTRACT

A review of the literature on physicians' perceptions of alcoholics and the elderly shows that scant professional or research attention has been given to the elderly alcoholic. Medical schools offer little training on alcoholism, fostering the impression that physicians do not have responsibility for treating alcoholic patients. An exploratory study of 26 physicians reaffirmed physicians' limited knowledge of, or interest in, addressing older patients' drinking problems, as assessed by physicians' responses to vignettes. These findings challenge the existing health care system, especially in light of the current demographic predictions that the proportion of the elderly population will increase substantially and the prevalence of alcohol-related problems in this age group. Strategies to address the drinking problems of the elderly are discussed.

Both the elderly and alcoholics are stigmatized groups in society: the elderly by the mere fact that they have grown old, alcoholics by their behavior, although this has diminished to some degree with greater social acceptance of the concept of alcoholism as a disease. This paper examines the stigmatization of elderly alcoholics and examines the fact that the drinking problems of the elderly receive little attention from physicians.

*The author is grateful for the assistance of William M. Holmes.

Although significant gains have been made in the last several decades to reduce alcoholism's stigma among the general public, this is less true among those who are in the helping professions. Those who have the responsibility for treating alcoholism continue to view alcoholics in a negative light (DiCicco-Bloom, et al., 1986; Brown, 1982; Murphy, 1980; Cantor, 1977; Straus, 1976; Jones and Helrich, 1972). In 1956, the American Medical Association designated alcoholism as a disease (Jellinek, 1960). This act represents one effort to bring alcoholism under the rubric of medicine. However, many physicians are still reluctant to treat alcoholics. If physicians do not consider alcoholism a disease, they can justify having no responsibility for treating patients with drinking problems.

The elderly alcoholic received almost no professional attention until the 1970s, and, since that time, professional interest has continued to be minimal. Kola, et al. (1984), in a survey of 88 social service agencies, document the lack of knowledge and concern for elderly alcoholics and their treatment needs. Nonetheless, Gurnack and Thomas (1989) depict five reasons that elderly alcoholism deserves greater public and research attention. First, the number of elderly in this country has increased and will continue to increase rapidly—numbers alone justify concern about alcohol problems later in life. Second, increasingly better educated elderly have become more willing to avail themselves of mental health services due to more positive attitudes toward psychiatric services. Third, an increase in alcohol abuse in later life is predicted because younger cohorts include more heavy drinkers and fewer who abstain from alcohol. Fourth, physicians are likely to mistake the effects of alcohol abuse in the elderly for irreversible dementia. Misdiagnosed patients may receive custodial care rather than treatment for their alcoholism. Fifth, early identification and treatment of drinking problems in the elderly would preclude expensive long-term institutionalization.

An exploratory study was undertaken to examine physicians' attitudes and treatment of elderly people with drinking problems. Physicians are in an excellent position to identify and offer treatment for patients' alcohol problems. The intent of this study was to learn more about how physicians perceive drinking problems and what types of interventions they are willing to make with elderly alcoholics. The vignettes compared the level of physician intervention offered to elderly and younger alcoholics.

Prevalence of Alcoholism Among the Elderly

Though sparse, the literature on elderly alcoholism indicates that drinking problems among the elderly are more far-reaching than is generally recognized.

Table 1
Prevalence Estimates of Elderly Alcoholics

<u>Study</u>	<u>General Population</u>	<u>Hospitalized</u>	<u>Nursing Home</u>
<u>Researcher-Identified</u>			
Zimberg (1978)	10-15%	>10-15%	
Blose (1978)			40-60%
Malcolm (1984)	10%		
Horton (1986)	10%	15-20%	20%
Curtis, et al. (1989)		21%	
Laforge, et al. (in press)		18%	
<u>Self-Identified Alcoholics</u>			
Abrahams and Patterson (1978)	1.6%		
Guttman (1978)	1.1%		

The treatment literature distinguishes between the early onset and the late onset drinker (Zimberg, 1974; Finlayson et al., 1988). The early onset alcoholic, with a long history of alcoholism, has simply survived into old age. The late onset alcoholic develops drinking problems later in life, typically as a response to life factors associated with aging—retirement, loss of spouse, isolation from family and friends, medical problems, and other social factors—although risk factors are not clearly identified (Israelstam, 1988; Atkinson, 1984; Gurnack and Thomas, 1989). Early onset alcoholics comprise two-thirds of the elderly alcoholic population, while late onset alcoholics comprise one-third (Zimberg, 1978). Zimberg (1978) and Williams (1984) acknowledge the variance in estimates of the number of elderly alcoholics and the need to better identify elderly with drinking problems. In general, most research estimates the prevalence of alcoholism to be between 10 and 20 percent while only a very small proportion (1-2 percent) of older drinkers identify themselves as alcoholic. Table 1 reviews prevalence estimates of elderly alcoholism.

Graham (1986) suggests that self-report techniques may not be appropriate with the elderly, as they may have difficulty remembering recent alcohol consumption, especially if they have no job or regular schedule to help with recent memory. The elderly take more prescription drugs than any other age group, which may also impair their memory. There is also a concern about the possible interactions between alcohol and medication. In addition, the elderly may have few relatives or friends to recognize and confront them about drinking.

The literature clearly reveals higher objective estimates of elderly alcoholism by researchers than self-reports of drinking behavior reveal. These issues underscore the importance of physician recognition of drinking problems and willingness to offer help to the elderly with drinking problems.

Several factors, however, hinder physicians' willingness to recognize or offer help to elderly alcoholics. Among these are the negative perceptions which physicians hold of both the elderly and alcoholics.

Physicians' Perceptions of the Elderly

The stereotyping of the elderly in American society hardly needs explanation. Physicians, like the rest of society, have been socialized into this negative view, and it is no surprise that they carry these views into their practice. Coccaro and Miles (1984) found, in a review of 17 studies, that medical students, educators, and practicing physicians held indifferent or negative attitudes toward geriatric education and geriatric medical care.

Greene, et al. (1987) found that fewer psychosocial issues were raised by patients and physicians in interviews with elderly patients. Physicians were also found to be less responsive to psychosocial concerns raised by the elderly.

Studies affirm that physicians' negative attitudes toward the elderly are fostered by their involvement with only the sick and debilitated elderly (Adelman and Albert, 1987; Linn and Zeppa, 1987).

Physicians' Perceptions of Alcoholics

Straus (1976) points out that we have not come very far in reducing the negative attitudes of health professionals toward alcoholics. He attributes this, in part, to the concept of "derived stigma." If health professionals become identified with alcoholics, they fear they will become labeled and lose favor with other patients (or peers). Therefore, professionals are reluctant to risk acquiring the lower status of their patients, inhibiting the development of positive professional attitudes toward alcoholics.

The sparse literature on physicians' perceptions of alcoholics reveals very strong agreement that physicians hold negative views of the alcoholic. Jones and Helrich (1972) found that 7 out of 10 physicians agreed that alcoholics were uncooperative and difficult patients. Cantor (1977) found that physicians thought time, effort, and money spent to achieve an accurate medical diagnosis were not worthwhile because alcoholics rarely followed

recommendations. House staff felt that treatment of alcoholic patients was not part of their primary responsibility because there were treatment programs designed specifically for the alcoholic.

Jeffery (1979) found that alcoholics without other readily identifiable health problems were considered "rubbish" by physicians. Alcoholics were less deserving of medical attention than patients who were "good" or "interesting"—those cases which helped physicians to further their professional careers. Alcoholics were viewed as responsible for their own drinking problems and as likely to refuse to cooperate with medical recommendations.

Riley and Marden (1946) found in a survey that 43 percent of physicians reported that alcoholics did not cooperate with medical treatment, while 28 percent reported that alcoholics caused specific annoyances and were a nuisance. Only 5 percent of the physicians reported that alcoholics created no special problems. Not much has changed over time in physicians' perceptions of alcoholics.

Another issue is that physicians may not discuss a drinking problem because they do not recognize that alcohol is a problem. Consequently, alcohol problems often are missed by physicians who lack training on alcoholism and the desire to treat alcoholic patients. This is especially true with elderly patients. If alcoholics are seen as unpleasant to deal with, it is no surprise that physicians avoid the issue. Mullin (1978) notes that physicians are likely to avoid discussions of drinking behavior with patients because it is uncomfortable for them. Lukash (1979) reports that physicians' unwillingness to confront patients about a drinking problem is the most critical issue in treating alcoholic patients.

The more recent literature reaffirms that discomfort in identifying and treating alcohol problems can result in physicians having a very narrow definition of alcoholism, which often excludes the elderly. Moore, et al. (1989) found that patients identified as alcoholic by physicians were significantly more likely to be younger, male, nonwhite patients of low socioeconomic status who admitted to relatively heavy alcohol intake.

Research Setting

No interview studies which examined physicians' perceptions of elderly alcoholics were located in the literature. Therefore, an exploratory study was carried out to assess physicians' perceptions of elderly alcoholics, with special attention to whether physicians were less responsive to the drinking problems of the elderly than they were to the drinking problems of younger patients.

The study involved semi-structured interviews with physicians in a resort/retirement community in the Northeast. All physicians (n=26) who treated elderly patients were included in the study. Due to revisions in the interview guide, four interviews were not comparable and were excluded from some analysis.

The exploratory study revealed that medical school training was minimal, at best, for the 26 physicians. Six received no training at all on alcoholism. Twenty received some training, usually limited to a few hours. Only one physician in 26 received any information on the drinking problems of the elderly while in medical school. Length of time out of medical school (2 to 35 years) was not related to training on alcoholism. The physicians also revealed their lack of interest in alcoholism, in that only 4 stated that medical schools should be doing more training on alcoholism.

Results

General Attitudes

Twenty-two physicians in this exploratory study were asked whether alcoholic patients created special difficulties for physicians. All 22 responded that alcoholics did create problems for them. One physician referred to alcoholics as "obnoxious dirt balls." Another physician stated:

They lie. They're unreliable, don't show up for appointments, don't take medications, don't follow advice. They're irresponsible, demanding. They call in the night.... You spend thousands of dollars, stay up all night, give time, effort, and money. They have no insurance. It's unsatisfying. They go right back to drinking.

Many other physicians were similarly strong in their negative characterizations of alcoholics.

Physicians were asked specifically whether elderly alcoholic patients created any special problems for them. Several physicians commented that elderly alcoholics had more severe medical problems than younger alcoholics. Many physicians appeared to avoid giving a direct response to the question by talking about something else, reaffirming that they may have little knowledge of, or experience with, elderly alcoholics.

One issue under study was the tendency of physicians to ask elderly patients about drinking behavior less often than they ask younger patients. One physician acknowledged this to be the case: "There is some subconscious tendency to not ask the little old lady with apple pie. You don't ask her about cocaine."

Even if there was evidence of a drinking problem, physicians were less likely to intervene with the elderly patient. One internist reported that he was much less likely to intervene with the elderly patient "...unless there is indisputable evidence. I feel I'm being disrespectful." It appears that respect for the elderly patient can take precedence over health issues which involve alcohol.

Physicians revealed that they considered it less important to know if an elderly patient had a drinking problem than if a young patient had the same problem. A cardiologist had this to say about the elderly alcoholic:

I'd be working against bias. They'd be harder to change. The bias is that it is less important to do so because of age. The elderly person who is having seven to eight drinks a day.... The doctor will tolerate this and is less likely to force the elderly to stop drinking. There is much more concern for the 45-year-old if he is having seven to eight drinks a day.... They've [the elderly] done it this long. They deserve what comes. I don't believe it won't hurt. I know this is a value judgment. It's not worth my effort.

These comments reveal that physicians have less knowledge of drinking problems among the elderly and consider it less important to intervene with the elderly.

Vignettes

The vignettes were designed to compare physicians' treatment strategies for elderly and younger alcoholic patients. The intent was to collect more detailed data on how physicians interpreted and acted on their patients' alcohol problems and to determine whether physicians' recommendations were based on age.

Twenty-two physicians were presented with two vignettes at the end of the interview. The first vignette described a 76-year-old widower admitted to the hospital after he came to the hospital emergency room smelling of alcohol and voicing complaints of severe abdominal pain, vomiting, and diarrhea. A medical workup revealed a diagnosis of cirrhosis of the liver. The physicians were asked the question: "How do you handle this situation?" After the physicians responded, the interviewer asked them to respond to a second vignette which described the exact same scenario, except that the patient was a 44-year-old male.

Physicians' responses about treatment fell into 3 major categories: 1) referral to an inpatient alcoholism treatment program; 2) referral to the hos-

Table 2
 Vignette Options Recommended by Physicians
 Age of Patient

Physician Recommendation	76-Year-Old	44-Year-Old
Inpatient Treatment	3 (14%)	15 (68%)
Alcoholism Counselor	11 (50%)	7 (32%)
No Treatment	8 (36%)	0 (0%)
Total	22 (100%)	22 (100%)

pital alcoholism counselor, who talks with patients during their hospital stay; and 3) no recommendation for any treatment for the alcoholism. Table 2 depicts the treatment options recommended for the 2 patients.

The results of the study reveal that the younger patient would more often be offered treatment for alcoholism (100 percent vs. 64 percent) and would receive the recommendation for more intensive inpatient alcoholism treatment than the elderly patient (68 percent vs. 14 percent). A referral to the alcoholism counselor represents the opportunity for the patient to talk about the drinking problem. This was recommended more often for the elderly patient (50 percent vs. 32 percent), and represented an intermediate level of intervention. Although no physician indicated that the alcohol problem of the younger patient would be ignored, over one-third (36 percent) of the physicians reported that the drinking problem of the elderly patient would not result in a recommendation for any treatment.

Only 5 physicians would have had the same level of intervention with both the elderly and the younger patients. These 5 physicians all said that they would refer both patients to the alcoholism counselor.

Many of the 22 physicians acknowledged that they would not offer the same interventions to both patients and that age was the determining factor as to how much intervention was provided. Only one physician indicated that he would give the elderly patient more attention than the younger patient, by being "more coaxing and supportive," as this physician felt that the elderly patient would be more likely to return to him for follow-up care.

The vast majority of the physicians acknowledged a lower level of intervention with the elderly patient. Almost all of this group would recommend that the younger patient receive some type of treatment—a talk with the hospital alcoholism counselor, Alcoholics Anonymous, or an inpatient alcoholism rehabilitation program. This was not the case for the 76-year-old; 8 physicians would not offer any treatment at all for the alcohol problem.

Several physicians stated that they would be more "confrontive" with the younger patient. In revealing that he would recommend inpatient treatment

for the 44-year-old but not for the 76-year-old, one physician stated: "I'm not sure of the rationale. More chance for success. The [younger] person is more receptive. The younger person has more long term risk due to drinking."

A typical response showed more optimism for the younger patient: "He has good years ahead and is more likely to have a reversible problem." The physician would try to get him into Alcoholics Anonymous and might encourage him to enter the local inpatient alcoholism rehabilitation program. For the elderly patient, this same internist saw loneliness as a big factor and said he would help the 76-year-old by "trying to introduce him to a nice widow"—a clear indication that the drinking problem was not taken too seriously.

Regardless of the treatment recommendations made to the patients, these physicians acknowledged that they would make a greater effort to get the younger patients to accept their recommendations. One physician said that he would "push harder" with the younger patient to get him to accept help. His rationale was that the younger patient has more life span and "...more productive life ahead of him. The older person is not as rehabilitable."

Several physicians indicated during the interview that they would treat the elderly and the younger patients the same, only to contradict themselves in the vignettes. One physician reported that he would try to get both patients, regardless of age, into an alcoholism rehabilitation program. He clearly expressed more concern about the effects of the alcoholism on the younger person, however, especially on how family members would be affected: "I'd be more aggressive. There are more lives at stake. The younger person presents more of a social emergency. He has more to live for."

The strongest reaction to the vignettes came from a physician who had a special interest in treating patients with alcohol problems. In responding to the vignette about the elderly person, this physician outlined her efforts to encourage him to accept treatment. Regarding the vignette about the younger patient:

This is important. I have a visceral reaction. I'd be on this guy right away. Get in touch with his girlfriend. I'd be all over him like a bad smell. I have a real visceral response. The only difference is a number [age]. You have to be discreet with the elderly. You're not quite as aggressive and hopeful. I got it right here in my gut. There is a difference.

This physician, like many other physicians, had not previously considered whether her interventions with alcoholics were based on the patient's age.

She assumed she would treat both the same and was surprised to learn that she would make a greater effort to engage the younger person in treatment.

In sum, the vignettes revealed that the vast majority of physicians would be more concerned, more active, and more aggressive with the younger patient with a drinking problem. They saw the younger patient as more worthy of their efforts and the efforts of other professionals. The age factor could indeed determine the level of involvement physicians have with patients with drinking problems. Even the few physicians who had a special interest in treating alcoholic patients revealed the likelihood of greater intervention with the younger patient.

Conclusions and Recommendations

The literature and the exploratory study reaffirm that most physicians have little knowledge of or interest in the drinking problems of their patients. Medical school training fails to give physicians the message that interventions in patients' drinking problems are a physician's responsibility. Medical school training on alcoholism has been restricted to specific isolated programs in a few medical schools (Chappel et al., 1977). Murphy (1980) notes that none of the interviewed physicians said they had learned anything useful about alcohol problems in medical school. A survey by the American Medical Association in 1984 revealed that 86 percent of physicians reported that lack of training in medical school was the most important reason for lack of confidence in diagnosing and treating alcohol problems (Cotter and Callahan, 1987). Importantly, Chodorkoff (1967) and Chappel, et al. (1977) found that medical students who did receive training in alcoholism developed more positive attitudes toward alcoholics and their recovery.

Unfortunately, medical education on alcohol problems appears to be on the decline. In the 1970s, the federal government sponsored the Career Teacher Program designed to implement alcohol education in 50 medical schools. The program ended in 1981 (Medical Education Still Needs Attention, 1989).

It would be very appropriate and easy to conclude with the recommendation that physicians should receive more training in medical school on alcoholism. Also, physicians' attendance at educational programs addressing patients' drinking problems should be required for medical licensure. However, the fact that there has been little interest in the 35 years since the American Medical Association designated alcoholism as a disease makes it seem unlikely that physician interest will increase without concerted efforts. Physician time and energy are increasingly consumed by keeping abreast of the latest technological developments, concern over managed

health care systems, and coming to grips with new demands, such as the AIDS epidemic.

The attitudes of physicians toward alcoholics in general, and elderly alcoholics in particular, are certainly worthy of more research attention. Physicians' attitudes toward alcoholics should be compared with attitudes toward patients with other types of illness, such as diabetes and heart disease. Are physicians' interventions also based upon the patient's age in these cases?

Since it appears unlikely that physicians will show a greater interest in uncovering and treating drinking problems in the current circumstances, it is appropriate to explore new strategies to address the drinking problems of the elderly. One strategy worth considering is for physicians to routinely administer to new patients an objective questionnaire, such as the Michigan Alcoholism Screening Test [MAST] (Selzer, 1971) or its short revised version, the SMAST (Selzer, et al., 1975) to quickly, easily, and reliably assess whether a patient has a drinking problem (Moore, 1971; Westermeyer, et al., 1978). The use of these tests would reduce the awkwardness both physician and patient can feel in a discussion of alcohol consumption. An alternative is Lukash's (1979) recommendation to administer blood alcohol tests as a standard laboratory test for every patient admitted to a hospital.

Yet another strategy would be to train other professionals who work closely with physicians, such as nurses and social workers, in the assessment of drinking problems. Mental health professionals would be excellent candidates for training, as they are likely to already have some knowledge of the community alcoholism treatment services. Emergency room physicians and nurses could utilize specialized training, as staff very often treat patients with alcohol problems. Yet another possibility would be for alcoholism professionals to become part of the hospital staff and to serve in a consulting role to physicians and other professionals.

Still another strategy emphasizes training with community agencies that offer services to the elderly, such as Visiting Nurse agencies, Meals on Wheels programs, and homemaker agencies. Agency staff would benefit from training in how to assess elderly clients for alcohol problems and how to refer the clients to resources available to treat elderly alcoholism.

All of these alternatives seem plausible and deserve further research.

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