

Physicians' Perspectives on Prescribing Benzodiazepines for Older Adults: A Qualitative Study

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BACKGROUND: There is a continued high prevalence of benzodiazepine use by older community-residing adults and of their continued prescription by practitioners, despite well known adverse effects and the availability of safer, effective alternatives.

OBJECTIVES: To understand factors influencing chronic use of benzodiazepines in older adults.

DESIGN: Qualitative study, semistructured interviews with physicians.

PARTICIPANTS: Thirty-three practicing primary care physicians around Philadelphia.

APPROACH: Qualitative interviews were audiotaped, transcribed, and entered into a qualitative software program. A multidisciplinary team coded transcripts and developed themes.

RESULTS: Physicians generally endorsed benzodiazepines as effective treatment for anxiety, citing quick action and strong patient satisfaction. The use of benzodiazepines in older adults was not seen to be problematic because they did not show drug-seeking or escalating dose behavior suggesting addiction. Physicians minimized other risks of benzodiazepines and did not view monitoring or restricting renewal of prescriptions as an important clinical focus relative to higher-priority medical issues. Many physicians expressed skepticism about risks of continued use and considerable pessimism in the successful taper/discontinuation in older patients with long-term use and prior failed attempts. Physicians also anticipated patient resistance to any such efforts, including switching physicians.

CONCLUSIONS: Primary care physicians are averse to addressing the public health problem of benzodiazepine overuse in the elderly. Their attitudes generally conflict with practice guidelines and they complain of a lack of training in constructive strategies to address this problem. A 2-pronged effort should focus on increasing skill level and preventing new cases of benzodiazepine dependency through improved patient education and vigilant monitoring of prescription renewal.

KEY WORDS: geriatrics; qualitative research; benzodiazepines; primary care; physicians.

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INTRODUCTION

The potential negative side effect profile and toxicity of benzodiazepines on older adults has been well established. Problems associated with benzodiazepine use by the elderly include sleep disturbance, cognitive difficulty, impairment in activities of daily living, motor vehicle crashes, and gait concerns (e.g., accidental falls and fall-related fractures).^{1–6}

Guidelines defining the appropriate use of benzodiazepines in the elderly recommend prescriptions be intermittent, brief, and for purposes of acute symptom relief.^{7,8} Despite guidelines, benzodiazepine use in older adults remains high with a mean current prevalence of 12.3% (ranging from 9.5% to 20%) in community-dwelling populations.^{9,10} Continuous use is deemed high and likely reflects unnecessary or suboptimal treatment.^{11,12}

As the main prescribers of these drugs, primary care practitioners are the most likely source of information that will help understand and eventually solve this public health problem.

PARTICIPANTS AND METHODS

This study explored possible explanations of chronic use of benzodiazepines in older adults through qualitative analysis of in-depth interviews with primary care physicians. Thirty-three physicians were recruited from the Philadelphia area through postal mailings, word-of-mouth, and phone solicitations with deliberate efforts to diversify experience level and practice setting. A semistructured interview guide was constructed to explore a wide range of potentially relevant issues, with the assistance of 2 board-certified geriatric psychiatrists, a medical anthropologist, and a sociologist.

DATA COLLECTION AND ANALYSIS

Interviews were conducted by an experienced research psychologist specialist in geriatrics and dissemination (JMC) and audiotaped, face-to-face ($n=28$) or by telephone ($n=5$). The interview first inquired about how the physician conceptual-

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ized clinical problems of acute life stress, insomnia, anxiety, and depression in older patients, with specific emphasis on the role for benzodiazepines. The interviewer then assessed the typical way in which the physician would, with an elderly patient, consider prescribing a benzodiazepine; evaluate treatment response and adverse effects; and decide to renew prescriptions. Finally, physicians were asked about strategies for identifying and addressing problems with benzodiazepine use, including the availability and use of psychotherapy as an alternative. Verbatim transcriptions of interviews were entered into QSR NVivo (version 2.0) for coding and analysis.

Narrative analysis proceeded systematically in 3 main steps: generating initial themes through independent study and rational analysis of transcripts, abstraction and condensation of themes through further discussion to identify common themes and reconcile conflicting observations, and creation of summary statements for each theme.¹³ Additional physicians were interviewed until no new concepts were identified (theoretical saturation). In summary, procedures used to ensure the internal validity of this qualitative study include semistandardization of the interview, audiotaping and professional transcription, standardized data coding, and an iterative approach to thematic extraction.

RESULTS

Thirty-three physicians (22 men and 11 women) participated. Mean age was 47; 29 were Caucasian, 3 were East Indian, and 1 was Asian. Practice characteristics were full-time practice²⁴ or part-time⁷; group practice²⁴ or solo practice⁹; suburban¹⁷ or inner city¹⁶; and family medicine,¹⁸ geriatrics,¹⁰ or general internists.⁵

In general discussion, physicians expressed agreement with current guidelines identifying benzodiazepines as mainly appropriate for short-term treatment only, not a stand-alone treatment for major depressive disorder, and not first-line treatments for long-term anxiety or chronic insomnia.

Understanding the Disparity Between Beliefs and Practice

In contrast to stated beliefs about best practice, physicians estimated that 5–10% of their older adult patients were using benzodiazepines on a daily basis for at least the past 3 months. Evidence was found for 3 overarching themes that were meaningfully distinct, but interrelated (Table 1).

Physician Minimization of the Problem. Virtually no physician considered benzodiazepine use among the elderly to be a priority clinical or public health problem. Four recurring subthemes supporting this conclusion were identified (see the 4 following subsections).

1a. No Addiction Seen in this Population. A number of physicians appeared to have different rules and strategies for prescribing these medications in older versus younger adults, and were more tolerant of long-term use in the elderly.

In younger age groups I'm more suspicious of abuse of it and sellin' it.

Table 1. Categories Underlying Use of Benzodiazepines in the Elderly

Categories

Physician minimization of benzodiazepine use as a problem
No addiction seen in this population
Little recognition of adverse effects other than addiction
Continuation is compassionate; discontinuation is harsh
Low-priority relative to medical problems
Justification of short- and long-term benzodiazepine use
Effectiveness for anxiety and sleep problems
Belief that stable dosage equals safe and effective
Attempt to discontinue will fail
Anticipated resistance from patients
Cost-benefit: Question patient gain and highlight suffering involved in taper or discontinuation
Wider organizational factors and system constraints
Limited physician time
Poor reimbursement for mental health care
Older patients limited acceptance and access to mental health services

Once you put them on it it's very difficult for them to come off, so as patients get older I become much more lenient with my prescribing... maybe I can empathize with them more... they're now pretty much set in their ways.

If it looks like it's close to the end of that person's life, you know, why bother... just let them go in peace.

Thus, a primary consideration in the prescription of benzodiazepines to older adults was the low potential for abuse and addiction. This seemed to be framed as a "moral" issue rather than a clinical question of balancing adverse effects—that is, the adverse effect of iatrogenic abuse/dependence.

1b. Little Recognition of Adverse Effects Other than Addiction.

You know, is it... terrible for somebody like that to be on 3 mg of Klonopin a day for the rest of their lives? If it works and she doesn't abuse it, who cares?

The potential for adverse health effects other than iatrogenic addiction were largely minimized or ignored, and guidelines were criticized as out of touch with real-world problems. Regardless of whether this perception is accurate, it is likely a major barrier to addressing the problem.

1c. Continuation is Compassionate; Discontinuation is Harsh.

Lacking strategies for both successful taper and alternative treatment, physicians did not want to withhold a medication that provided ongoing relief to the patient and believed that reducing or discontinuing benzodiazepines would unnecessarily cause undue suffering.

Let's pretend it's an octogenarian ... if it's gonna make the patient feel better, I don't care if the patient's on it for the rest of their life.

You'd like to say, well, I can just put a great big brick wall in front of me and the patient with benzodiazepines but it doesn't work that way... You feel like you've gotta give the patient something to help.

Id. Low-Priority Relative to Medical Problems. Physicians spoke about competing medical management issues that were of higher priority during relatively brief medical appointments.

The sad fact is their primary care doctors make choices... there's almost sort of a running tally going on in your head when you're talking to a patient. Do I want to open this can of worms right now or do I want to deal with these four other things that are gonna result in a heart attack if I don't deal with them, or a stroke. Or do I want to deal with this other thing that I know is going to be incredibly time-consuming and difficult, and difficult to deal with this patient, when I don't think that the therapy is really that bad for them.

In the greater scheme of things I have a feeling there are other problems that are much, much worse.

Justification of Short- and Long-Term Benzodiazepine Use. The majority of physicians were somewhat vague and reluctant to describe the circumstances in which they would prescribe benzodiazepines in new patients. Five related subthemes were identified (see the 5 following subsections).

Ila. Effectiveness for Anxiety and Sleep Problems. Physicians emphasized that benzodiazepines are rapidly, highly effective for anxiety and sleep problems, despite the fact that they are not first-line treatment for insomnia.

Sometimes it's the easiest choice for people to feel best quickly. They feel better fast.

They sometimes feel that the other ones don't work. I mean it's not such an immediate effect... everybody likes an immediate effect. If you don't have an immediate effect then sometimes you feel that it's not working and you won't give it time to work.

Ilb. Belief that Stable Dosage Equals Safe and Effective. Physicians reasoned that a benzodiazepine at a stable dose for months-years was probably helping and doing no harm.

I don't push it 'cause the downside is she seems to tolerate it fine, it's not a high dose, it hasn't escalated and she finds it beneficial. I'm not worried about fifteen or twenty years down the road I'm gonna still be giving her Ativan. She's not gonna be alive in twenty years down the road and I'm sort of surprised she's alive now... She really needs it. If it helps her get through her days better, great.

Ilc. Attempt to Discontinue will Fail. Almost all of the physicians noted that they had tried and failed to taper and discontinue benzodiazepines in some patients. None had a systematic strategy for addressing patient concerns that inevitably emerge during this process.

I suggest to them that ideally we should try to get them off of that, but if they're saying, been there, done that,

that didn't work for me when I came off of this, I don't think it's worth getting into a big knock-down drag-out [fight] with them or having them leave my practice over this issue.

It is a doctor throwing his hands up in resignation in, oh my god, she's been on it for years, I'll just give her what she asks for and I won't have to sit here and explain things for twenty minutes about why I want to get her off. 'Cause it is, it is an effort and time and frustration trying to get people off of these things. So maybe it's just the path of least resistance.

Ild. Anticipated Resistance from Patients. Physicians anticipated resistance in response to even broaching the topic of taper/discontinuation with an older patient. Prospects ranged from questioning the doctor's authority and competence, to minimization of potential negative side effects, to finding another doctor who was willing to prescribe it.

Every time I tried to say Lorazepam isn't the right medication, she said, 'but I've been on it for thirty years.' I think they enjoy the effects of the benzodiazepine and they don't want to have that taken away. It's literally like taking candy from a baby and people that have enjoyed the effects of that class of drugs don't wanna give it up. I can't lose patients over this.

Ile. Cost-benefit: Question Patient Gain and Highlight Suffering Involved in Taper or Discontinuation. In the end, physicians believed the advantages of continuing benzodiazepines in the elderly outweighed the problems.

You don't wanna take somebody who is functioning well and create a situation where they function badly and a situation where they are sort of utilizing normal health care resources currently. You know, seeing me intermittently, three, four times a year... being stable with respect to their relationships, etcetera, and create a situation where they are calling me every two, three days.

Wider Organizational Factors and System Constraints. Several physicians expressed frustration that system constraints made it impossible for them to provide the more comprehensive care they wanted to give their patients, summarized in 3 subthemes (see the 3 following subsections).

IIla. Limited Physician Time. Physicians cited time constraints as both promoting benzodiazepine use and impeding discontinuation efforts.

A benzodiazepine becomes a quick fix because you don't have time, this is what they want, they don't feel good, here it is. It numbs them up and you're not gonna get a phone call afterwards, you're not gonna get anything, you'll see them in a month, here's your renewal, see ya later.

It's just so much easier to just prescribe something and just walk away.

IIb. Poor Reimbursement for Mental Health Care. Lack of parity for reimbursing treatment of mental health problems in primary care was frequently mentioned in this context.

Medicare... will not reimburse any internist for a psychiatric diagnosis.

Reimbursement is very low... I think if it was something that we did get reimbursed on I think you would see physicians' attitudes a lot different. You'd be more willing to spend time.

IIc. Older Patients Limited Acceptance and Access to Mental Health Services. Physicians thought their older adult patients would resist or be unable to pursue mental health referrals for multiple reasons ranging from stigma to financial and transportation difficulties.

I think patients in my office are much more ready to admit the fact that taking this medicine now is cheaper and simpler and easier and less stigma, nobody knows about, etcetera and [patients think] I can do that forever and I would rather do that and keep a lid on things than have to deal with everything else that's under the surface in my life and try to sit down with somebody and talk it out and pay co-pays every time I go to see somebody. And then finding somebody that can do that, who I trust and like and it becomes an onerous, tedious, almost overwhelming task.

DISCUSSION

Physicians were aware of practice guideline recommendations. However, none believed benzodiazepine use was a serious clinical problem in older adults, and all believed there were multiple barriers to addressing use in real-world practice, including that raising the issue would threaten their alliance with patients.

Physicians focused almost entirely on "addiction" as the main concern with benzodiazepine use and discontinuation, and their reasoning seemed based on moral rather than scientific criteria, with frequent mention of "drug addicts" and "drug-seeking behavior." Most physicians focused on dependency as an adverse effect to the exclusion of all other adverse effects, and then evaluated their own prescribing patterns based on this formula. Herein seems to be another disparity between guidelines generated by academics and the actual behavior of community practitioners.^{14,15}

We found that physicians believed that attempts to reduce benzodiazepine use in the elderly would threaten their alliance with these patients. Physicians expressed dissatisfaction about a lack of preparation to address the issue, reflected in a lack of concrete strategies. Concerns about patient resistance were thus compounded by physicians' lack of a sense of efficacy in addressing the difficult clinical issues that would be raised if they approached older patients about continuous benzodiazepine use.

Limitations of the present study include possible selection bias in the willingness of physicians to be interviewed about a potentially sensitive topic and possible social desirability and defensiveness in the responses provided in the interview.

However, physicians were generally forthcoming about the ways in which their practice patterns differed rather markedly from guidelines. They quite simply disagreed with them.

Four randomized controlled trials have examined interventions for reducing benzodiazepine use in the United Kingdom and Canada. The results are equivocal. In a prospective, randomized, 3-cell clinical trial in and around London, Heather and colleagues¹⁶ found that long-term users who received a letter from their physicians suggesting a reduction in the use of benzodiazepines, and those who received this letter plus 4 monthly information sheets about dose reduction and coping without it, significantly reduced their benzodiazepine intake over a treat-as-usual condition.¹⁷ However, another British study found no efficacy for a minimal intervention consisting of advice from a general practitioner and a self-help booklet versus treatment-as-usual.¹⁸

Over the past 2 decades, physicians in the United Kingdom have received substantial advice about the problems associated with prescribing benzodiazepines, and the British national formulary states that hypnotic drugs should be avoided in elderly people.¹⁷ In addition, the National Health Service recommends identifying long-term benzodiazepine users and planning for discontinuation if possible.¹⁹ In the decentralized health care system in the United States, organizing systematic and system-wide programs such as these are extraordinarily difficult.

In Ontario, Canada, a randomized controlled trial of confidential feedback and educational material to primary care physicians that aimed to reduce benzodiazepine use in elderly patients was also ineffective.²⁰ Virtually all research to date finds that older adults have increased vulnerability to serious adverse effects of these drugs.^{1-6,11,12} However, simply creating and disseminating guidelines based on this research is ineffective in changing practice patterns.

Recent U.S. legislation gives the appearance of addressing this issue using a rigid economic (rather than educational) approach. The Centers for Medicare and Medicaid Services excluded benzodiazepines from coverage in Medicare Part D, along with a seemingly unrelated list of other medication categories including barbiturates, medications to promote weight loss or weight gain, fertility, hair growth, and nonprescription drugs.²¹ This set of exclusions was taken verbatim from the Omnibus Reconciliation Act of 1990, and the benzodiazepine exclusion seems to have been the result of lobbying by activist groups, namely, Ralph Nader's Public Citizen organization.^{22,23} It is notable that all states essentially overruled this decision by continuing to cover benzodiazepines, with some states adding additional restrictions or monitoring.²¹ In response to the recent Medicare Part D legislation, numerous professional and patient advocacy organizations have called for removal of the benzodiazepine exclusion because it could result in dangerous, abrupt discontinuation of benzodiazepines, and obstructs the appropriate use of these medications.^{21,24}

A 2-track public health strategy could potentially address the issues we identified in this study. First, because physicians agreed in principle that short-term treatment with benzodiazepines is the best practice, education and training programs could teach physicians how to present this model to patients and implement it effectively. Because traditional continuing medical education programs are ineffective at producing behavioral change, more research is needed to develop effective

programs for both practicing physicians and postgraduate training programs. Senior faculty and attendings should be included in any such effort.

A second effort aimed at training physicians in the skills of taper and discontinuation of benzodiazepines will likely require a more large-scale, expensive, and multipronged effort. To be effective, the program would need to convince physicians of the threats to the health of the elderly involved in this practice and provide some experience with specific counseling skills.

Difficulties in getting physicians to change their practices, even when supported by recommendations, are considerable and well-documented.^{14,15} This study explicated primary care physicians' perspectives on reasons for not addressing the chronic use of benzodiazepines among older patients and the formidable challenges if they decided to do so. Such research provides a more sympathetic perspective on the practicing physician that can in turn lead to more engaging, persuasive efforts to change their behavior.

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