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Primary Care Physicians' Attitudes, Beliefs, and Actions Toward Geriatric Treatment

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Walden University
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Abstract

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MPH, Walden University, 2020

Post-Bac, Fielding Graduate University, 2017

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

In the United States, an estimated 49.2 million older adults seek specialized geriatric medical treatment from a primary care physician (PCP). Due to a nationwide geriatrician deficit resulting from significant aging population growth, PCPs now manage specialized geriatric issues, such as Alzheimer's disease, cognitive assessments, and physiological impairments, such as Parkinson's, due to non-normative aging. Although PCPs may take geriatric courses, geriatric specialization is beyond a normative primary care medical practice. The purpose of this generic qualitative study was to explore primary care physician attitudes, beliefs, and actions, toward geriatrics and to expand the understanding of primary care physicians' geriatric treatment decisions inclusive of prescriptive planning. For this generic qualitative study, the theory of planned behavior was the framework. Nine participants were primary care physicians currently practicing in Oregon with a minimum 20% geriatric patient base. Utilizing thematic analysis initially interviews were coded for key terms and phrases with color-coordinated highlights, then grouped into major categories which then emerged five themes. Five themes emerged with limitations of geriatric patient care due to Medicare restrictions, need for a greater comprehensive and integrative approach with mental and social services, understanding polypharmacy and medication interactions, barriers to patient care due to limitations of family support with social and environmental factors, and joy and fulfillment treating geriatric patients The results of this generic qualitative study potentially benefit PCPs nationwide, highlighting gaps in best practices, issues specific to geriatric care, and geriatric training that may provide further exploration.

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Dedication

I dedicate this dissertation to my loved ones who have inspired, encouraged, and uplifted me throughout this academic path. I also dedicate this study to my dear mother and all those with Alzheimer's who have passed away.

Acknowledgments

I want to thank my dear family and friends for their encouragement, love, and support during these many years completing my doctorate. My sincerest gratitude to my dearest friends Cheryl and George Stevens who carried me when I forgot how to carry myself. Thank you to those who have loved me unconditionally showing me the strength in community. I also want to thank Dr. Greg Hickman and Dr. Barbara Benoliel for their support, guidance, and compassion—without which I would not be here today. Also, my deepest gratitude to my "Diss Family" for being on this path together in love.

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Chapter 1: Introduction to the Study

Introduction

Geriatric care is significantly increasing in the United States, with more than 50 million older adults seeking care (Airagnes et al.,2016; Rhee & Rosenheck, 2019). As a direct result of limited specialized geriatricians, primary care physicians (PCPs) treat older adults (age 65 and older), comprising over 40% of their patient practices (Cantor, 2017; Roberts et al., 2018). Although PCPs can treat geriatric and age-related issues, specialized geriatric care is limited for most PCPs (Cantor, 2017). Complex geriatric issues and symptoms of degenerative diseases, such as Alzheimer's, are often misdiagnosed and are challenging to treat, leading to overmedicating, which can cause secondary symptoms (Chen & Steinman, 2016). The result of aging population growth—increases of 18 million by 2030—predicates the need for more geriatricians to supplement care and for further geriatric education for PCPs (Bernstein et al., 2019). Given the aging population trend, PCP geriatric patient growth is expected (Bernstein et al., 2019). Cunningham et al. (2019) suggested further exploration of best practices, age-related issues, and PCP treatment options for comprehensive care is needed.

Understanding nuances of PCP geriatric treatment is essential for optimal care and best practices, as PCPs are the primary provider for geriatric patients (McCarthy et al., 2017). McCarthy et al. (2017) posited that PCP adaptability and comprehension with geriatric care are essential with aging population growth. Additionally, current American Medical Association (AMA) models limit integrative treatment, thus prompting primarily prescriptive options (Petersen et al., 2018). Older adult polypharmacy is at critical levels

surpassing 44% in ages 65 and older (Petersen et al., 2018). According to Morin et al. (2018), excessive levels of 10 or more prescriptive drugs are prevalent in 13% of the aging population. Typical geriatrician practices provide comprehensive and integrative assessments that focus on medical, psychological, and environmental factors (Cantor, 2017). As aging population growth increases so does the need for extensive geriatric care (Chen & Steinman, 2016). Given that PCPs treat most geriatric patients, in this research, I explore PCPs attitudes, beliefs, and actions toward geriatric care (Cantor, 2017; Chen & Steinman, 2016).

This chapter includes a background of the significance to PCP geriatric care and how PCP behavior impacts treatment. Roger's social–psychological theory of planned behavior (TPB) and Ajzen's theory of reasoned action (TRA) provided the theoretical framework for this generic qualitative study (Ajzen, 1991; Rogers, 1985). This study's nature includes the methodology, strategy, PCP population sampling, and key definitions. Also, in this section, I review the assumptions, scope and delimitations, limitations, and the significance of the study.

Background

In the United States, polypharmacy within the geriatric population has reached significant levels with averages of 10 or more psychotropic medications prescribed for diagnosed anxiety, sleep, depression, posttraumatic stress disorder, or pain by PCPs (Lai et al., 2019). Falls, injuries, emergency room visits, bone breakage, and early mortality result from polypharmacy interaction of medications (McKenzie et al., 2017). PCPs diagnose geriatric conditions, such as Alzheimer's disease, which are complex and have

comorbidity impacts (Petrazzuoli et al., 2017). Cantor (2017) posited that because of limited skillsets, PCPs treating geriatric patients misdiagnose Alzheimer's and continue to perpetuate polypharmacy. Zhang et al. (2019) suggested Alzheimer's and complex geriatric conditions require extensive geriatric knowledge and education. Fischer et al. (2017) demonstrated more than 24% of Alzheimer's diagnoses were misdiagnosed with incorrect prescriptive treatment planning.

Additionally, Roberts et al. (2018) reviewed census statistics for the U.S. aging population and the significant aging trends affecting growing demographics. Geriatrician shortages and aging demographic growth increase PCP geriatric patient populations (Chen & Steinman, 2016). Bernstein et al. (2019) concurred, denoting how a lack of geriatric assessments by PCPs correlates to misdiagnoses in geriatric communities. PCPs currently have a 30%–40% geriatric patient base, which requires knowledge and education of advanced geriatrics for diagnoses, treatment planning, and mental and behavioral care (Fischer et al., 2017). Due to aging population growth, increased PCP geriatric patient demographic, and limited geriatricians, understanding PCP geriatric care attitudes provides insight and knowledge.

In the current literature focus has been on social conditions such as polypharmacy, dementia misdiagnoses, and increased aging injuries; however, a gap in the literature exists on understanding PCP attitudes toward geriatric care. This research addressed PCPs attitudes, beliefs, and actions toward geriatric care. Understanding the background and development of behaviors provides insight into PCP geriatric care. Ajzen's (2002) TPB was the basis and foundation for behavioral examination. Finally,

according to Chavez et al. (2018), geriatric diagnosis and treatment planning requires advanced education and understanding of comprehensive geriatric care.

Problem Statement

In the United States, an estimated 49.2 million older adults seek specialized geriatric medical treatment from a PCP (Airagnes et al., 2016; Rhee & Rosenheck, 2019). Due to a nationwide geriatrician deficit of approximately 10,000, resulting from a significant aging population growth, PCPs now manage specialized geriatric issues like Alzheimer's (Cantor, 2017; Roberts et al., 2018). The aging population influx will increase by 18 million in the next decade, increasing PCPs' patient base further (Airagnes et al., 2016; Rhee & Rosenheck, 2019). PCPs are now managing specialized age-related issues like Alzheimer's, cognitive assessments, and physiological impairments as Parkinson's due to non-normative aging (Chen & Steinman, 2016; Cunningham et al., 2019). Although PCPs may take geriatric courses, geriatric specialization is beyond a normative primary care medical practice (Bernstein et al., 2019).

Concurrently, researchers have found that polypharmacy, prescriptions greater than five, in older adults is increasing and showing significant levels of dependence and addiction; however, little research has been focused on the epidemiology of prescriptions issued for geriatric patients (Bobo et al., 2019; Cullinan et al., 2016). Aypak et al. (2016) and Rolland and Morley (2016) posited that the concomitant use of prescriptions is prevalent in 62% of geriatric patients being treated by PCPs. Geriatric polypharmacy increases negative secondary health factors, reduces metabolic rates causing falls or incidents, aggravates chronic medical conditions, and can cause early mortality.

Nonetheless, PCPs continue to overmedicate and misdiagnose (Bobo et al., 2019; Levine, 2017; Maree et al., 2016).

Alzheimer's misdiagnosis impacts treatment planning, healthcare costs, and quality of life (Eichler et al., 2018; Lai et al., 2019). Bernstein et al. (2019) and Lai et al. (2019) theorized that dementia misdiagnosis is significant with PCPs lacking geriatric knowledge. Geriatric treatment planning recognizes physiological and behavioral impacts and cognitive impairments, demanding extensive knowledge and experience in which PCPs are deficient (Bernstein et al., 2019). The American Geriatric Society posited that understanding the dynamics of treatment planning is imperative for PCPs providing geriatric care (Whitson et al., 2018).

Although researchers in PCPs treating geriatric populations have demonstrated important findings, I have found no research that involved examining PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions. Further research is needed to examine PCPs attitudes toward geriatrics impacting their treatment decisions (Bernstein et al., 2019; Bobo et al., 2019; Cunningham et al., 2019; Rhee & Rosenheck, 2019).

Purpose of the Study

The purpose of this generic qualitative study was to explore PCP attitudes, beliefs, and actions toward geriatrics and to expand the understanding of PCPs' geriatric treatment decisions (Cunningham et al., 2019; Rhee & Rosenheck, 2019). This generic qualitative study aimed to gain a greater understanding of geriatric care within PCP

practices concerning geriatric patient treatments. In this generic qualitative study, I explored mitigating factors of PCP behaviors impacting geriatric care.

Research Question

What are PCPs attitudes, beliefs, and Actions toward geriatrics impacting treatment decisions?

Conceptual Framework

The theoretical framework of this generic qualitative study comprised the premise of Ajzen's (2002) social–psychological TPB and TRA (Fleming et al., 2017). TRA posits those actions, or motivations, toward a behavior as attitudes, subjective norms, and perceived behavioral control impact behaviors (Ajzen, 2002; Fleming et al., 2017). According to Ajzen (1985), individuals are intrinsically logical, making reasonable decisions with information already available to them and nonmotivational factors as "facilitating conditions" or availability of time. An individual's performance or success with their behavior is determined by knowledge, self-efficacy, attitude, and social support (Ajzen, 1985). Behaviors are shaped by attitudes toward behavior, understanding of social norms, and perceived intentions determining action (Ajzen, 2002). Ajzen's TRA categorizes behavior into three areas: (a) social norms, (b) attitude toward behavior, and (c) perception of controlled environment allowing for interpretation of actions (Fleming et al., 2017).

The TRA application to my study of PCP attitudes toward geriatrics impacting treatment decisions was used to explore the behavioral influence of PCPs' education, experiences, and subjective norms (Fleming et al., 2017). According to Ajzen (2002) and

Fleming et al. (2017), planned behavior theory applies to qualitative research semi structured interview questions categorizing social norms, attitudes, and perceptions of actions based on environment. The TRA also applies for the narrative data collection categorization of PCPs motivational and nonmotivational influences as the theory indicates the "degree to which a person has a favorable or unfavorable evaluation or appraisal of the behavior in question" and the social pressure of a behavior (Buhmann & Brønn, 2018; Fleming et al., 2017). TRA was used to guide open-ended questions and the data analysis categorizing interview questions for interpretation based on behavioral intent (Fleming et al., 2017). In the discussion section, TRA was the baseline aiding in interpreting results based on the categorized influences of attitudes, social norms, and perception of controlled behavior (Arevalo & Brown, 2019; Fleming et al., 2017).

Nature of the Study

The nature of the study was a generic qualitative approach. A generic qualitative study approach was appropriate for exploring the attitudes, beliefs, and actions of PCPs toward geriatrics (Gammelgaard, 2017; Liu, 2016; Taylor & Bogdan, 1984). The purpose of this study was to expand understanding of how PCPs attitudes toward geriatrics impact treatment decisions including prescriptive planning. Generic qualitative research design was best to explore the social dynamic of PCPs providing geriatric care and their attitudes toward it (Gammelgaard, 2017; Liu, 2016). A generic qualitative study design also allowed for a complex social dynamic, such as geriatric care, to be explored in depth with open-ended questions, allowing PCPs to share insights (Devota et al., 2016; Liu, 2016). Kahlke (2018) indicated that a generic qualitative study aligns the social relationship of a

particular group to a social issue for greater understanding. This generic qualitative study was the best approach allowing PCPs, who are currently treating geriatric patients in the state of Oregon, to provide a narrative of their attitudes toward geriatrics and expand on their motivational and nonmotivational influences (Kahlke, 2018; Percy et al., 2015).

The procedures of this generic qualitative study were data collection from semi structured interviews conducted on an online face-to-face platform and recorded. Interview recordings were transcribed and printed to allow for organization and coding (Devota et al., 2016; Linneberg & Korsgaard, 2019; Liu, 2016). Semi structured interview questions allowed PCPs to expand on experiences, attitudes, and more in-depth exploration of geriatrics to understand the impacts, if any, on prescriptive treatments (Devotta et al., 2016; Linneberg & Korsgaard, 2019; Percy et al., 2015). Questions were open ended for a narrative approach and categorized by the TRA guidelines of attitudes, subjective norms, and perceived behavioral control (Ajzen, 1985; Ajzen, 2002; Arevalo & Brown, 2019; Buhmann, & Brønn, 2018; Fleming et al., 2017). All data were recorded via an online meeting platform, printed from the transcript, and interpreted incorporating TRA categories of motivational and nonmotivational influences (Ajzen, 1985; Ajzen, 2002; Fleming et al., 2017).

PCPs were purposefully sampled through social media platforms and were the target population for the study. Purposive sampling used for the targeted population of Oregon PCPs represented the social dynamic of PCPs currently treating geriatric patients (Campbell et al., 2020). An advertisement was posted on social medical platforms, as approved by the Walden University Institutional Review Board (IRB). Criteria for PCPs

who voluntarily participated in interviews were those currently treating geriatric patients in their practice and were selected by answering the questionnaire proposed. PCPs were homogenous in nature, each having a family practice in the state of Oregon. In similar generic qualitative studies, Ploeg et al. (2017) and Austin et al. (2020) used 20 or more participants meeting data saturation levels.

Data analysis and interpretation of PCPs attitudes toward geriatrics, with relevant themes of behaviors, conditions, and factors influencing treatments, were explored (Fleming et al., 2017; Redman et al., 2019). Interpretation of trends and themes were interpreted individually with each PCP's answers and then analyzed together for commonality of patterns or topics (Linneberg & Korsgaard, 2019; Pettersson et al., 2017). Qualitative data analysis was aligned with the purpose of this research exploring PCPs attitudes toward geriatrics and impact on prescriptive treatments (Clark, & Vealé, 2018; Devotta et al., 2016). Analyzed common themes developed were aligned with the TRA and categorized accordingly for underlying influences (Ajzen, 1985; Ajzen, 2002; Vaughn & Turner, 2016).

The method for organizing the data was thematic analysis transcribed in a Microsoft Word document using a six-step process (Lawless & Chen, 2019; Nowell et al., 2017). Familiarized data themes were coded and labeled with each topic, context, and keywording defined for interpretation (Ajzen, 2002; Clark & Vealé, 2018; Devota et al., 2016; Lawless & Chen, 2019; Nowell et al., 2017). Using TPB with thematic analysis aided in interpreting themes and understanding the relationship to behavioral outcomes (Arevalo & Brown, 2019; Fleming et al., 2017).

Trustworthiness and validity were accomplished by triangulation using the same sources, questions, and methods with data collection for each PCP (Arevalo & Brown, 2019; Clark & Vealé, 2018; Cypress, 2017; Vaugh & Turner, 2016). Validity was achieved by using consistent measures in participant and thematic coding. Cypress (2017) noted that triangulation is achieved by consistent measures, and within this explorative study, coding applied to data collection, transcription, and analysis. Rigorous methods to ensure validity were used through coding and member checks and ensured no researcher bias by peer reviews of methodology, journals, and analysis (Clark & Vealé, 2018; Thomas, 2017). Clark and Vealé (2018) conjectured that ensuring validity and trustworthiness in a qualitative study is the role of the researcher through consistent methods, minimizing bias, and clear interpretation.

Ethical research standards were upheld in this study by standards of the IRB. Ethical standards applied to this qualitative study by anonymous participation of PCPs listed only by alphanumeric coding, initial documentation of PCP consented to use data, and ensured patient confidentiality with coding (Cypress, 2017; Vaughn & Turner, 2016). Each PCP received an initial consent form via email acknowledging use of data, participant anonymity, and patient confidentiality by use of applied alphanumeric coding (Linneberg & Korsgaard, 2019). All emails, interview recordings, and correspondence were only managed by me, the researcher, were contained in a locked filing cabinet, and will be stored for 5 years as required (Laydner et al., 2017).

Definitions

Age-related issues: Include normative medical, physical, and mental conditions pertaining to older adults (Pettersson et al., 2017).

Attitude: Muslim et al. (2020) noted this as, "Tendency of the mind to act in a certain way based on experience and behavior" as defined by Eagly and Chaiken (1993). Theoretical constructs of attitudes are posited as experiential perceptions determining behaviors (Ajzen & Fishbein, 2000).

Beliefs: Defined from or by attitudes about the world around us that portend truth or fiction (Shommer, 1994). Duff et al. (2017) posited that epistemological beliefs determine daily actions.

Geriatric: Refers to older adults (ages 65 and older) who experience multiple health issues simultaneously requiring specialized health care; does not refer to all older adults, only those ages 65 and older adults who have multiple health conditions (Voumard et al., 2018).

Neurocognitive disorder: Defined by the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., Perminder et al., 2014), neurocognitive disorders are explained by "three syndromes; delirium, mild neurocognitive disorder, and major neurocognitive disorder." Neurocognitive disorder is a decline in normative brain synopses functioning, impairing motor and mental capabilities (Vahedian-Shahroodi et al., 2019). For purposes of this research, neurocognitive disorder is specific to dementia, specifically Alzheimer's disease (Perminder et al., 2014).

Polypharmacy: Multiple prescriptive medication usage (Masnoon et al., 2017). Polypharmacy in older adults is prevalent with five or more prescriptions in the United States (König et al., 2018).

Specialized geriatric care: Distinct care for aging populations experiencing comorbidities provided by geriatric medical providers, gerontologists, or comprehensive specialized professionals (Chavez et al., 2018).

Assumptions

I assumed that PCPs in the Oregon Geriatric Society would provide open answers to interview questions for this generic qualitative study. Additionally, I assumed that PCPs would share recollections accurately. PCPs would recall attitudes, beliefs, and actions toward geriatric care, understanding adequate definitions. Also, I assumed that PCPs would openly share experiences from their geriatric practices. The answers from this generic study assimilated with trending and cohesion of constructs using thematic analysis (Wolgemuth et al., 2017). Lastly, I assumed that PCPs would view the explorative study as relevant to academic development and understand the anonymous nature to answer questions honestly (Rahi, 2017).

Scope and Delimitations

The delimitation of this study was the outreach to PCPs via social media outlets, which provided easier and quicker responses for sampling. Social media platforms offer access to Oregon PCPs who treat geriatric patients, overcoming time constraints of completing this generic study. The scope of the study was designed specifically from the TPB and TRA (Ajzen, 2002), focusing on attitudes, beliefs, and actions. Statistically,

PCPs treat 30% of geriatric patients, which allowed for the interview questions to be answered with extensive experience (Campbell et al., 2020). Consequently, analyzing themes comprised the TPB theoretical approach of attitudes, beliefs, and determining behavior (Ajzen, 2002).

Limitations

Limitations to this study were a potential bias on the part of me, the researcher, as I advocate for upholding aging rights and the minimization of overmedicating geriatric patients. To ensure bias did not implicate a barrier to the questions, a peer review from a secondary editor, the Walden University committee, was conducted (Clark & Vealé, 2018; Thomas, 2017). Incorporating appropriate no subjective language and minimizing persuasive attitudes minimized any bias (Charles & Dattalo, 2018). Additional challenges to this study might have been bias of the participants in sharing information, although data were confidential, as well as timely interview responses (Branion-Calles et al., 2019). A barrier to this generic study was generalizability, given the smaller participant sampling (Redman et al., 2019). Redman et al. (2019) posited that despite limited generalizability of generic qualitative studies, the context could provide insight for a social issue. Lastly, reflexive memos provided transparency, minimizing any researcher bias (Corrall, 2017).

Significance

This research fills a gap in the literature on understanding PCPs attitudes, beliefs, and actions toward geriatric care in their practices and the impact on treatment decisions (Airagnes et al., 2016; Miller et al., 2017). This study provided nuances of PCP geriatric

care, the impact on physicians, and decisions of geriatric treatments (Walsh et al., 2017). The results of this generic qualitative study potentially benefit PCPs nationwide, highlighting gaps in best practices, issues specific to geriatric care, and geriatric training that may provide further exploration (Walsh et al., 2017).

Additionally, nationwide, geriatricians, gerontologists, and geriatric professionals may benefit from this study by learning of how to provide integrative and comprehensive geriatric care needed supporting PCPs (Cullinan et al., 2016; Miller et al., 2017). The AMA and national organizations, such as the Aging Institute, Alzheimer's Association, and the World Health Organization, may benefit from the findings of this study of viable options to support PCPs as the aging population continues to grow (Whitson et al., 2018). Lastly, this study can support the need for enhanced university geriatric programs creating specialized courses for integrative geriatric care (Whitson et al., 2018).

Given this study was conducted in Oregon, local aging agencies, such as the Aging Institute, Alzheimer's Association Oregon, and Advocacy and Services of LGBT Elders, may benefit from this study in understanding how to support PCPs with age-related issues, geriatric treatments, and diversity within geriatric care (Whitesone et al., 2018). Lastly, local state and county aging agencies may gain greater awareness with this study enhancing geriatric credentials needed for PCPs who treat older patients. This generic study could lead to potential implications for positive social change by addressing geriatric care and the social problem of overprescribing for a growing aging population.

Summary

This research was founded on the premise of increased geriatric polypharmacy, significant PCP geriatric demographic growth, and needed geriatric care reform. Exploring attitudes, beliefs, and actions of PCPs, in this research, I sought to provide insights into behaviors toward geriatric care. In this generic qualitative study, I explored responses with thematic analysis seeking themes that postulated awareness into behaviors of PCPs' geriatric care. More than 49.2% of geriatric patients are seen by PCPs who diagnose conditions, such as Alzheimer's, provide cognitive assessments, and treat prescriptively long term (Airagnes et al., 2016; Rhee & Rosenheck, 2019). Airagnes et al. (2016) posited that between the aging demographic growth and limited geriatricians, geriatric care demands greater attention.

The theoretical framework consisting of Ajzen's TPB (2002) specified a basis for understanding the behavior of PCPs treating geriatrics. Attitudes, beliefs, and actions of PCPs are significant precursors to the treatment planning of geriatric patients (Ajzen, 2002; Rankin, 2019). Rhee and Rosenheck (2019) and Masnoon et al. (2017) posited that comprehensive care beyond prescriptive treatments is needed for minimizing polypharmacy and secondary conditions resulting. Cognitive assessments; meeting geriatric medical, mental, and behavioral health care; and understanding impacts of polypharmacy on aging and age-related conditions is critical as aging populations increase (Rankin, 2019). This generic qualitative study provided insight to a social crisis evident and growing at significant rates (Austin et al., 2020).

As the demand for geriatric care increases, the medical and health care industry must enhance their protocols, practices, and long-term treatments (Lai et al., 2019). PCP practices comprise over 30% of geriatric patients, requiring enhanced knowledge, aging and age-related education, and mental and behavioral healthcare collaboration of PCPs (Lawless & Chen, 2019). Further understanding could address a gap in the literature regarding PCPs attitudes, beliefs, and actions toward geriatric care.

In the following section, I review literature supporting the basis of this research, the framework, and outlining the methodology reasoning and overview of the topic. In the literature review, I explore the supporting articles for geriatric care overview, historical insight of geriatric care, and current social issues. Also, in this next section, I examine the reasons for focusing on PCP geriatric practices and the theoretical framework and basis for this research, TPB (Ajzen, 2002). I also explore comprehensive geriatric treatment planning, advantages and disadvantages of integrative care, and future studies.

Chapter 2: Literature Review

In this chapter, I explore key terminology and behavioral concepts, geriatric treatments, theoretical background, and framework through published literature. Also, historical perspectives governing geriatric practices supply reference for current primary care physician planning. Behavioral elements of PCP geriatric treatments as attitudes, beliefs, and actions are addressed in this chapter as well. Finally, a synthesis of the literature on the reasoning and background of this research completes this chapter.

Literature Search Strategy

I performed my literature review with articles empirically evaluated and published through databases including EBSCOhost, ProQuest, PsycINFO, Google Scholar, and Thoreau. Current and relevant articles supported my research and key topics. In locating current articles, keywords used were: *geriatrics, polypharmacy, multimorbidity, primary care physicians, attitudes, beliefs, actions, behaviors, generic qualitative studies, theory of planned behavior, theory of reasoned action, geriatric treatment planning,* and *comprehensive care.*

Keyword searches resulted in more than 300 current articles published from 2017 to present day. Articles published prior to 2017 were only used for theoretical originality and verification support. Articles reviewed were evaluated for relevancy of my topic and synthesized in my research. Continuous assessment of articles allowed me to stay on topic with my research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions inclusive of prescriptive planning? Relevant

articles supported my research, critiqued the validity and credibility, and posed significant points of view.

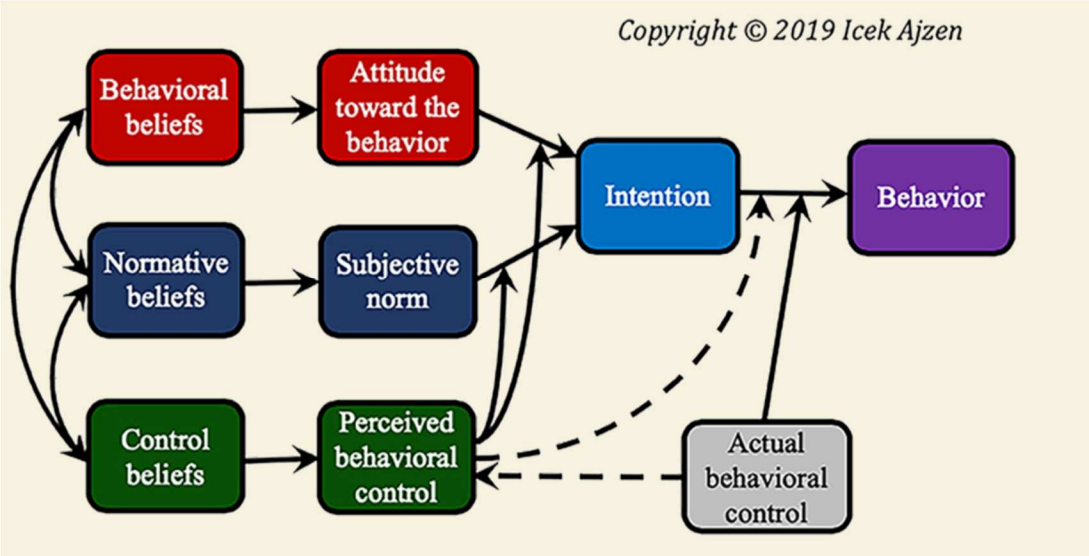
Theoretical Foundation

TPB (Ajzen, 1985, 1991) developed from Ajzens' original TRA (Sarver, 1983). Understanding how behavior developed from systematic processing of information shows a causal trajectory from beliefs to behaviors. In this research, I used TPB (Ajzen, 1991) as a foundation and framework. Predicting an individuals' behavior based on selective questions, integrated with intentions and motivations, is the basis for TRA (Ajzen & Kruglanski, 2019; Madden et al., 1992). Kippax and Crawford (1993) incited limitations with TRA, explaining "behavioral change" and environmental impacts alter behavior. Ajzen (1985, 2002) advanced the beginnings of TRA to TPB, including beliefs and attitudes determining, and precursors to, behavior. Explanations to the inclusion of beliefs and attitudes show psychological and cognitive constructs factored into forming behaviors (Ajzen, 1985, 2002).

The beginnings of planned behavioral theory were founded in social psychology in the functioning of daily habits and behaviors within society (Ajzen, 1985). Ajzen and Fischbein (2000) originally explored relationships with beliefs and attitudes to behaviors, a direct causal link; however, intentions and motivations were later added to solidify TPB in social psychology. Ajzen (2011) responded to critics, such as Zoellner et al. (2000), regarding the behavioral social model interjected by unconditional constructs impeding behavior.

Figure 1

Planned Behavioral Theory Diagram (based on Ajzen, 2019)



Note. Adapted from and permission granted for academic use by Ajzen, I. (2019). https://people.umass.edu/aizen/tpb.background.html

Behaviors within TPB begin with subjective, normative, and controlled beliefs, coupled with attitudes toward the behavior (Ajzen, 1985, 2002). Additionally, Madden et al. (1992) posited that the intention or motivation and ability of an individual directly predicts a behavioral outcome. Ajzen (1985) and Madden et al. (1992) developed TPB for behaviors including social health issues such as smoking or extended alcohol use and organizational psychology issues such as completing tasks. According to Valois et al. (2020), concomitantly TPB is used to predict achieved behaviors based on causal relationships of positive attitudes and beliefs in the field of geriatrics. Beliefs are subjective, normative, or controlled, predicting the outcome behavior by intentions and motivations (Vahedian-Shahroodi et al., 2019). Overall, in predictive behavior of PCPs in

geriatric care, TPB is a foundation for greater understanding into the treatment directives and decisions (Nahapetyan et al., 2019; Stolte et al., 2017).

Additionally, TPB includes both attitudes and beliefs predicting behaviors with controlled beliefs a factor in the formulation (Ajzen, 1991; Bosnjak et al., 2020). Bosnjak et al. (2020) noted that TPB provides a high prediction accuracy of attitudes and beliefs to behaviors with minimal variance. Concurrently, Glasgow et al. (2004) supported TPB with an addition of contextual factors influencing behavior, specifically within physicians' practices. Furthermore, Steinmetz et al. (2016) substantiated the reliability of using TPB in assessing how physicians' behaviors coupled with influential factors, such as controlled beliefs on patient care, guide interventions. More recently, Srivastava and Bodkhe (2020) noted how influential factors of pharmaceutical companies marketing to physicians determined treatment planning outcomes of prescriptive measures. A high reliability of TPB testing for Srivastava and Bodkhe's (2020) research concluded relational probability of behaviors by contextual factors, such as marketing, with a low sum of variance.

In the past two decades, TPB has propelled studies of physician practices. Srivastava and Bodkhe (2020) examined prescriptive marketing factors, Sprenger et al. (2017) determined physician behaviors toward e-health options, and Burgess et al. (2017) associated reliability with attitudes toward usage of evidence-based practices. Although TPB has been incorporated in studies in various fields, including medical (Steinmetz et al, 2016), education (Sun et al., 2017), or industrial (Kahlke, 2018), determinants showing a trajectory of attitudes, beliefs, and actions toward behavior are significant.

Applications for Theory of Planned Behavior

Understanding intentions and behaviors are achieved with TPB as a framework, and various fields apply TPB (Ajzen, 1991). Fields such as medical, organizational psychology, gerontology, and education have applied TPB as a research framework achieving correlations with attitudes, beliefs, and intention toward behaviors (Dewberry & Jackson, 2018; Gao et al., 2017; Lee & Kang, 2020). The social–cognitive TPB model aids researchers in understanding behavioral intent for indicators such as nurses' behavioral intent to care for patients (Ajzen, 1991; Lee & Kang, 2020). Lee and Kang (2020) used TPB in determining that the perceived behavioral control variable comprised 55% of the nursing sample toward treating infectious patients. Perceived behavioral control in addition to attitudes and beliefs toward behavior provide significant awareness for social conditions (Ajzen, 1991; Bosnjak et al., 2020; Burgess et al., 2017; Valois et al., 2020). Similarly, Piras et al. (2017) applied TPB in the medical application of nurses' hygiene, washing hands in hospital settings, and found that perceived control of behavior, as well as subjective norms, were critical for hand sanitizing. Piras et al. (2017) determined that understanding subjective norms and perceived control of behavior is valuable in creating programs for nurses that enhance sanitizing protocol.

In addition to medical applications of TPB, organizational psychology and a focus on business practices have included TPB. Srivastava and Bodkhe (2020) used TPB to understand the prescribing habits of physicians. Srivastava and Bodkhe used a questionnaire with 261 physicians, affirming that prescriptive branding efforts have a significant influence on prescription treatment. Buhmann and Brønn (2018) implemented

TPB in understanding effective applications of measures and evaluations of physicians toward communication. Measures and evaluations are significant to enhancing best practices of physician patient care and the inclusive TPB model provided insight to behavioral determination (Buhmann & Brønn, 2018).

Ajzens' TPB (1991) has been used in research of geriatric care and Alzheimer's patient treatments. Nahapetyanf et al. (2019) applied the TPB model focusing on attitudes and intentions of hospice care usage and concluded that an enhanced awareness program was necessary. Additionally, Vahedian-Shahroodi et al. (2019) applied TPB to understand the perceived norms, attitudes, and intentions of older adults and their motivations to be active. Understanding the attitudes and motivation of older adults' activity behavior is a significant contributor to the field of gerontology, promoting wellness and minimizing neurocognitive decline (Vahedian-Shahroodi et al., 2019). Valois et al. (2020) researched behaviors of older adults toward self-care with heat adaption for safety measures and concurrently applied TPB. Valois et al. (2020) found a significant correlation between heat adaptation measures and behavioral intention and knowledge. TPB (Ajzen, 1991) is applicable to sociodynamics of older adults and geriatric care, which allows for greater understanding of behaviors. Attitudes, subjective norms, and intentions leading to behaviors and behavioral change provide a foundation for researchers to enhance patient care (Ajzen, 1991; Bosnjak et al., 2020; Burgess et al., 2017; Valois et al., 2020).

Rationale

In this research, I explored the attitudes, beliefs, and actions of PCPs toward geriatric care using TPB as a foundation (Ajzen, 1991). As noted earlier, TPB is applicable to such fields as medical, organizational psychology, and for this research, gerontology. The aging demographic is significantly increasing with more PCPs treating geriatric patients in need of enhanced treatments (Airagnes et al., 2016; Cantor, 2017; Roberts et al., 2018). Comprehension of physician attitudes, beliefs, and actions toward geriatric care may provide insight into prescriptive treatment planning, overall geriatric care, and best practices for older adults (Chen & Steinman, 2016). Cantor (2017) and James et al. (2020) concluded that PCPs treating geriatric patients need enhanced best practices beyond prescriptive treatments. Incorporating TPB in my research helped provide tools and resources, such as surveys and questionnaires, that determined a significant reliability in measuring attitudes, beliefs, and actions toward behaviors (Ajzen, 1991; Ajzen, 2011; Armitage & Conner, 2001; Burgess et al., 2017).

Behaviors of PCPs toward geriatric care were determined by attitudes, beliefs, and actions (intentions) toward aging, treatment, and care (Burgess et al., 2017). Sequences leading to behaviors as subjective norms, beliefs toward expectations, or external factors impacting intention provided awareness toward geriatric treatments (Gao et al., 2017). A socio-cognitive theory, such as TPB, was the framework for my research which was necessary to comprehend PCP motives for geriatric care, especially as comorbidities, complications with neurocognitive disorders, and environmental factors contribute to wellness (Chen & Steinman, 2016; Steinmetz et al., 2016; Zhang et al.,

2019). Zhang et al. (2018) noted that geriatric care, specifically for Alzheimer's disease, must include a total modality approach to care, integrative care. Bosnjak et al. (2020) expanded on TPB's presence in current research, stating that TPB has been subject to 4,200 reviews validating the connection to attitudes and behaviors.

Additionally, consideration was taken in exploring alternative theories for my research of PCPs' geriatric treatment practices. Quantitative research methodology as utilized by Richters et al., (2018) applied complexity theory exploring facets of PCP treatments of a comprehensive approach toward geriatric care. Although the complexity theory provided an integrative review for a mixed-methods approach, my research was a singular exploratory study focusing on the reasoning and pre-emptive approach to PCP behaviors (Richters et al., 2018). Alternatively, Clark et al., (2017) applied behavioral change theory to understand behavior the inter-personal aspects of physical activity behaviors. My research focus was primarily on intra-personal aspects as attitude and beliefs rather than influences of environmental on behavioral change as the research of Clark et al. (2017).

Overall, TPB created a framework for understanding the determinants of behavior as attitudes, subjective norms, beliefs, and intentions (Ajzen, 1991, 2011). Attitudes are shaped by conditions from academia, nurture, or environmental, guiding decision-making (Kunneman et al., 2017). Similarly, Sun et al. (2017) concurred that attitudes are foundational in decisions. Walsh et al. (2017) determined that influences of decision-making are formed by attitudes and values we place on the specific behavior. For my research, TPB comprised elements for exploring PCPs attitudes and actions toward

geriatric care which allowed for greater understanding into treatment motivations (Ajzen, 2011).

For purposes of this study, Ajzen's TPB was the basis for exploration of beliefs toward behaviors which were positive or negative (Ajzen, 1991, 2011). Bosnjak et al., (2020) explored the significance of behaviors in current literature utilizing TPB, and the correlation of behavioral beliefs, normative beliefs, and control beliefs, toward behaviors. PCPs treating geriatric patients are performing neurocognitive assessments, Alzheimer's determinations, and long-term treatment planning, which require prompt decisions during a brief visit (Black et al., 2020; Lai et al., 2019). Exploring PCP behaviors toward geriatric care provided insight into behavioral motivators that allowed for quick patient decisions (Maree et al., 2016). Ultimately, the Theory of Planned Behavior provided a foundation for intra-personal motivators into PCPs behaviors within a geriatric setting (Buhmann & Brønn, 2018).

Additionally, the Theory of Planned Behavior aligned with the research question "What are PCPs' attitudes, beliefs, and actions toward geriatrics impacting treatment decisions inclusive of prescriptive planning". As noted earlier, behavioral motivators allowed for a in depth understanding determinants for geriatric care (Maree et al., 2016). As a generic qualitative study, interviews of PCPs were established with the fundamentals of TPB guiding questions with an intra-personal focus on attitudes, beliefs, and actions (Ajzen, 1985, 2011). Contributions of this study in the field of social cognitive psychology with the application of TPB, may potentially further substantiate the validity of TPB (Ajzen, 1991, 2011). As noted by Blaum et al. (2018), Cantor (2017),

and Lester et al. (2020), the aging population growth continues the need for enhanced geriatric care and exploring the aspects of critical PCP decision-making.

Finally, potential contributions of this study may enhance the collective group of PCPs promoting further understanding of attitudes through the framework of TPB study (Willis et al., 2020). Willis et al. (2020) and Caputo (2020) provided synthesis of group behavioral trends affecting patient care and potential health risks. PCP decisions toward geriatric patients are determined within a brief timeframe during a patient visit, thus exploring foundational basis for decisions is critical (Cantor, 2017; Lester el al., 2020). Providing further application to the Theory of Planned Behavior, this research examined behavioral control centered on decision-making for PCPs (Ajzen, 2011). This research contributed to group behavioral dynamics of decision-making of PCPs, exploring key elements of affective or cognitive basis for behaviors (Cantor, 2017; Lester et al., 2020). Lai et al. (2019) noted the importance of further research to enhance PCP geriatric practices.

Literature Review

Geriatric Care

Geriatric care is predominantly focused on medical assessments, diagnosis, and treatments of older adults (Blaum et al., 2018; Mulley, 2012). In general, older adults are not pre-determined to need geriatric care unless there are conditions of comorbidity, multiple health issues, critical physical or cognitive decline (Morley, 2004; Mulley 2012). Busetto et al. (2017) further extended that geriatric comprehensive care as an integrative approach of “health services” for older adults. Evans (1997) described the complexities

of aging may include frailty, multiple health conditions, neurocognitive decline, and environmental factors, for many older adults. In the United States, 47.8 million older adults are geriatric, with this statistic increasing significantly (Roberts et al., 2018). Although geriatric care has improved and progressed throughout the decades, Blaum et al. (2018), Cantor (2017), and Lester et al. (2020) suggested that geriatric palliative care is predominant with PCPs rather than restorative or curative treatments. Palliative care is treatment focused on pain management (Lester et al., 2020) Although many geriatric patients living with health conditions or neurocognitive disorders, despite the terminability of the disease.

Given the significant growth with Alzheimer's disease, geriatric treatment is critical and Blaum et al. (2018) and Cantor (2017) posited the severity and pervasiveness of AD, demands enhanced treatment methods. Currently, Fowler et al., (2020) determined the importance of comprehensive care with an Alzheimer's diagnosis, and the importance of accurate assessment. Similarly, Lai et al., (2019) confirmed the trajectory in geriatrics of comprehensive treatment planning inclusive of medical and psychological providers. Additionally, Lai et al. (2019) validated the importance of accurate and timely neurocognitive assessments and treatments. Also, Press et al. (2017), concluded, via data collection from 8 years of geriatric patient surveys, that PCPs require enhanced geriatric training for effective assessments, treatments planning, and long-term care.

PCPs not only require additional geriatric training for accurate assessments and treatment care, but PCPs also need comprehensive patient recommendations and long-term planning at noted by Lai et al. (2019) and Press et al. (2017). Limitations of PCP

geriatric care are overuse of prescriptive treatments, inaccurate neurocognitive assessments, and needs determinations as care providers, housing, and therapy (Cantor, 2017; Lester el al. 2020). Lester et al. (2020) noted limitations of PCPs understand aging and age-related issues as physiology, environmental elements, and comorbidities. Complexities within aging managing neurocognitive disorders, vascular conditions, physiological issues, and polypharmacy, require expertise for effective best practices for geriatric patients (Blaum et al., 2018). Busetto et al. (2017) found that multidisciplinary geriatric care most effective for rehabilitation and long-term care decisions. Long-term complexities of geriatric care according to Lester el al. (2020), require extensive training for not only current patient health issues but risk management. Overall, although PCPs are currently the predominant medical providers for geriatric patients, with growing aging population trends, awareness must be given to patient care (Blaum et al., 2018; Maree et al., 2016).

Focus on Primary Care Physicians

Given the relevancy that geriatric patients predominantly are treated by PCPs rather than geriatricians, the shortage of geriatricians, understanding current social issues surrounding care is critical (Cantor, 2017; Masnoon et al., 2017; Voumard et al., 2018). Socio-dynamic conditions warranting examination of PCP geriatric care are significant due to aging population growth, prescriptive treatments, and complexities of age-related health conditions (Petrazzuoli et al., 2017). Leung et al. (2018) and Bernstein et al. (2019) posited that PCP geriatric care demands awareness of attitudes and beliefs of aging for effective care. Geriatric syndromes as noted by Kang et al., (2020), are complex

requiring extensive knowledge for a greater patient-centered approach. Concurrently, Blaum et al. (2018) summarized those geriatric patients with multiple chronic conditions are not easily managed with evidence-based care and requires collaborative efforts for treatment planning. Overall, Kang et al. (2020) found current PCP geriatric care as requiring overview for "identifying risk factors", understanding patient priorities, and diagnosing complex chronic conditions.

Aging Population Growth

D'Haese et al. (2019) and Bergmann et al. (2017) considered the aging population growth a global pandemic inciting health care providers to consider a more comprehensive approach to geriatric care. As noted earlier, older adults comprise upwards of 16% of the total United States population, and that statistic is increasing annually (Bergmann et al., 2017). Nationwide, more than 50 million older adults have multiple chronic conditions demanding enhanced patient care as posited by Blaum et al. (2018). According to Conlon et al. (2017) "baby boomers" are changing the geriatric patient care needs. Also, Ward et al. (2021) concurred that increasing aging population growth, due to "baby boomers", requires extensive comprehensive geriatric care. Complexities of aging are inclusive of medical comorbidities, psychiatric conditions, and socio-environmental, needing integrative provider modality approach (Ward et al., 2021).

Geriatric needs demand a multi-tiered approach as noted by Ward et al. (2021) and Pederson et al. (2016), positing that PCPs are limited with only medical expertise. According to the National Institute on Aging (2017), older adults with multiple chronic conditions (MCC) comprise more than 60% of that demographic, requiring a multi-

variant approach for treatments. Costa et al. (2016) discussed multi-disciplinary geriatric treatment with medical and psychological modalities for accuracy of mental health assessments as the Geriatric Depression Scale (GDS). Ehrlich et al. (2020) presented the criticality of "baby boomers" aging, with 54 million over the age of 65 in 2018, and social issues as ageism must be addressed. Ageism among physicians is "ample" according to Ben-Harush et al. (2017), and attitudes toward diagnostic and treatment care reveals bias. Ultimately, PCPs attitudes toward geriatric patients determine interventions, management of complex conditions, and quality of life, as noted by Gomez-Moreno et al. (2019).

Ben-Harush et al. (2017) and Costa et al. (2016) postulated that the aging population growth is exceeding geriatrics with current conditions lacking in adequate direct care. Also, negative attitudes toward older adults impacts direct care, and PCPs experiencing ageism must address biases (Ben-Harush et al., 2017; Wyman et al., 2018). Lai et al. (2019) noted the importance of PCP awareness and knowledge of geriatric care as currently, approximately 77% of geriatric patients, globally, are either not diagnosed or properly diagnosed with dementia. Casado et al. (2018) further determined that PCPs are further remiss in dementia diagnosis with ethnic aging demographics. Researchers demonstrated current aging population growth demands greater awareness for geriatric patients focusing on medical conditions, mental health issues, and environmental factors, comprehensively (Ben-Harush et al., 2017; Lai et al., 2019; Wyman et al., 2018).

Prescriptive Treatments

In addition to PCPs need to manage medical and mental conditions for geriatric patients, aging population growth demands enhanced long-term care planning (Black et al., 2020; Lester et al., 2020). Lester et al. (2020) described the dire need for geriatric training amongst physicians for the complexities of care. According to Kok and Reynolds (2017) multi-conditions in geriatric patients require an integrative approach to management of medical, psychological, and functionality of a patient for best practices. PCPs' patients are comprised of approximately 30% geriatric patients, increasing annually, with complex health conditions (Frank et al., 2018). Wilson et al. (2017) noted the everyday geriatric management of issues as diabetes, coupled with dementia or Alzheimer's, and vascular irregularities, must have a multi-provider approach. Zhang et al. (2019) demonstrated that the need for prescriptive treatments is complex and interactive, often conflicting in remedy, and causing secondary medical crises as dizziness, fainting, vascular impacts, hallucinations, and even early mortality. Lastly, prescriptive treatments for both medical and mental conditions, according to Aypak et al., (2016) demands extensive knowledge by physicians and the inclusion of a mental health provider.

Prescriptive medications, as noted earlier, are complex and most geriatric patients are prescribed more than five medications, with potential interactive components (Lai et al., 2019). Wastesson et al. (2018) reviewed the urgent need for polypharmacy oversight in older adults and an integrative approach to geriatric treatments minimizing negative secondary conditions. Bhardwaj et al. (2020) concurred with geriatric medication

oversight noting that the prevalence of comorbidities as diabetes, vascular conditions, obesity, or dementia create complexities which lower accurate prescriptive management. Also, Wastesson et al. (2018), Bhardwaj et al. (2020), and Kok and Reynolds (2017) noted a multi-tiered provider approach is needed minimizing inaccurate geriatric assessments as well as appropriate prescriptive treatments. Kok and Reynolds (2017) posited that psychiatric disorders as clinical depression and dementia may present issues with multiple psychotropic medications intermingling with prescriptions for high blood pressure, diabetes, or vascular conditions.

Overall, polypharmacy is significant within the geriatric community and albeit a physicians' clinical judgment, multi-morbidities inclusive of psychiatric disorders is complex (Aypak et al., 2016). Wastesson et al. (2018) concluded that not all polypharmacy is negative for older adults however multiple psychotropic medications may induce frailty, falling, or early mortality for geriatric patients. Although pharmaceutical management is multifaceted in its approach, Morin et al. (2018) found that 44% of Swedish geriatric patients were prescribed more than five medications which had adverse secondary implications, and 12% with ten or more prescriptions. As, Bhardwaj et al (2020) and Rhee and Rosenheck, (2019) concurred, psychiatric medications prescribed by PCPs for geriatric patients must include a mental health provider for patient best practices.

Neurocognitive Assessments

In addition to understanding pharmaceutical aspects of geriatric care, mental health disorders, as Alzheimer's, are an inherent component of PCP patient care (Giles et

al., 2018). Press et al. (2017) concluded, in an 8-year study, that PCPs must attain geriatric training for enhance neurocognitive and geriatric assessments. Additionally, Wilson et al. (2017) found that comprehensive neurocognitive assessments and treatment planning can reduce polypharmacy. Concurrently, Aypak et al. (2016) reviewed patients with multiple medications, five or more, concluding that deprescribing has positive benefits for geriatric patients and does not shorten lifespan. Additionally, alternative therapies for cognitive decline and neurocognitive disease as Alzheimer's, according to Zhang et al. (2020), may slow the progression of AD as well as calm behaviors.

Behavioral and psychological symptoms of dementia (BPSD) are an integral component to Alzheimer's and management of behavioral volatility if critical for quality of life and risk management (James et al., 2020). Cunningham et al. (2019) noted that mental health diagnosis is more than a basic cognitive assessment survey and must include neuro-evaluation and/or mental health examination. Similarly, Mansbach et al. (2020) posited that understanding the progression of Alzheimer's is critical at early stages providing a quality of life and longevity, and PCPs with mental health consultation create the highest validation of accurate assessment. Early accurate assessment and progressive AD treatment planning, also noted by Mansbach et al. (2020) minimizes "health care burden", costs, and patient BPSD. Overall, ethical care, as remarked by Lauretani et al. (2020) considers a comprehensive patient-centered approach and best practices with integrative provider care.

Ethical Geriatric Care

According to Lauretani et al. (2020), ethical geriatric care considers multi-morbidities of patients necessitating effective diagnosis communication and a multi-tiered provider approach for medical and mental evaluations and treatments. Petersen et al. (2018) remarked that ethical conduct for medical professionals must include current expertise in specialties and explicit communication with patients and caregivers. Additionally, Pellegrini et al., (2017) noted that trust is the key element to effective patient care and communication is essential. Ethical geriatric care as defined by Low et al. (2019) must include "principles of autonomy, justice, beneficence and non-maleficence" demonstrated with clear communication with patients and/or caregivers. In a study by Lang et al. (2017), 63.7% (95% CI) of geriatric patients were not diagnosed with dementia or other neurocognitive disorders, with remaining patients often misdiagnosed. Low et al. (2019) posited that many geriatric patients with a diagnosis of neurocognitive disorder are not communicated the results. Ultimately, physicians must demonstrate current knowledge of geriatric care, effective communication skills, and long-term patient-physician partnership for ethical geriatric care practices (Lang et al., 2017; Low et al., 2019; Prins et al., 2016).

As noted earlier ethical geriatric care "principles of autonomy, justice, beneficence, and nonmaleficence" are critical for patient relationships (Low et al., 2019). Asprino et al. (2017) described autonomous care as patient-direct care focusing on the "medical, psychosocial, functional, and environmental" aspects of a patient. Asprino et al. (2017) noted that autonomous care is both understanding dementia diagnostic tools

and application or treatment for individual patient care. Lang et al. (2017) and Low et al. (2019) postulated that geriatric assessments are either misdiagnosed or not incorporated in patient diagnostics. Autonomy in geriatric patient care according to Prins et al. (2016) requires extensive neurocognitive knowledge for accurate diagnosis and treatment planning, as a significant percentage (63.7%) of primary physicians are lacking.

Neurocognitive knowledge and experience are components to ethical geriatric patient care and according to Giles et al. (2018), PCPs, being the primary geriatric provider, must advance expertise. Juujärvi et al. (2019) concurred, noting that in addition to autonomous patient-direct care, and justice, beneficence, and maleficence must be addressed. Low et al. (2019) determined ageism or aging bias interfered with PCP geriatric cognitive assessments within accuracies. Although Mason et al. (2016) noted limitations, the current social reality is that PCPs are the primary source of geriatric care and integrative neuro-assessments minimize bias or lacking in patient care.

Additionally, other aspects of ethical patient care are justice and beneficence, which Juujärvi et al. (2019) determined is limited within PCP geriatric care by inability to understanding neurocognitive diagnostic resources as well as aging progression and age-related conditions. Also, Mason et al., (2016) found that PCP's attitudes toward terminal diagnoses are precursors for limited treatments and conditional cognitive assessment tools. Ho and Neo (2021) posited that beneficence is present in geriatric care when, despite terminal diagnoses, treatment care planning is outlined with patient and caregiver. Juujärvi et al. (2019) concurred noting that comprehensive treatment planning inclusive of other providers meeting needs for medical, mental, and environmental support.

Primary care providers knowledgeable in geriatric practices, current in neurocognitive assessments, and collaborative with other providers, show justice and beneficence toward geriatric patients (Ho & Neo, 2021; Juujärvi et al., 2019; Mason et al., 2016).

Overall, PCPs' ethical geriatric care according to Low et al. (2019), must include "principles of autonomy, justice, and beneficence" maintaining the highest standards of medical practice. Schweikart and Eng (2020) observed that the PCPs must consider patient risk beyond the clinic room, weighing patient wellness with prescriptions, alternative provider care, and environmental factors. Impacts of limited patient risk management, are patient falls, injuries, potential early mortality, and Schweikart and Eng (2020) concluded that the AMA Code of Ethics is limited in detailing geriatric risk management. Schweikart and Eng (2020) further noted that beneficence and justice are elements present in comprehensive patient risk management for medical, mental, and environmental considerations. Low et al. (2019) concurred stating that PCPs can only thoroughly implement ethical care with current geriatric medical knowledge, integrative provider assessments, and communication with patient and/or caregiver. Ultimately, ethical geriatric care is lacking with PCPs and revisions to current medical standards must be addressed as noted by Ho and Neo (2021), Low et al. (2019), and Schweikart and Eng (2020).

Importance of Physician Attitudes and Beliefs

Given most geriatric patients in the United States are treated by PCPs, due to a lack of geriatricians, consideration of ethical care, prescriptive and alternative treatments, and patient overall wellness, are needed (Asprino et al. 2017; Ehrlich et al. 2020; Lai et

al. 2019). As noted by Schweikart and Eng (2020), PCPs attitudes toward both terminal diagnoses and overall geriatric care, determines patient treatment planning, ethical standards, and long-term care. Casado et al. (2018) assessed the importance of PCP perspectives and knowledge of geriatric care for patient involvement and commitment to long-term treatment planning. Cunningham et al. (2019) determined physician attitudes toward patient care correlates to patient autonomy and beneficence. Overall, PCP attitudes toward patient care are precursors for a higher standard of diagnosis, treatment planning, patient communication, and long-term care (Cunningham et al., 2019; Lai et al., 2019; Schweikart & Eng., 2020).

As noted, attitudes are predeterminants to behaviors, and according to Eagly and Chaiken (1993), in addition to early childhood conditioning and life experiences, attitudes and beliefs are essential to behavior formation. Concurrently, Ajzen (1985) considered social conditions that are negatively affected by a group's behavior, must be examined for change. Specifically, PCPs attitudes and beliefs toward geriatric care, aging, or treatment options are critical components of behavioral outcomes (Cunningham et al., 2019; Lai et al., 2019). Thi Thanh Vu et al. (2019) concluded that physicians' knowledge toward geriatric palliative is correlated with attitudes toward aging and beliefs toward geriatric care. According to Elbi et al. (2020), components as attitudes, beliefs, actions, must be regarded within the medical community treating geriatric patients, as negative PCP attitudes are affecting patient care.

In addition to attitudes, beliefs, according to Ajzen (1985) affect behavioral outcomes considering risk factors or consequences. Armitage and Conner (2001)

concurred noting the expectations of a behavior are prevalent with decision-making. Asprino et al. (2017) noted that PCPs deciding treatment planning are significantly influenced by the American Medical Association, pharmaceutical companies, and hospital protocol. In a study by Srivastava and Bodkhe (2020), pharmaceutical marketing strategies influenced physicians toward a particular prescription. Again, expectations, and environmental influences determine behavioral outcome. In a study by Price et al. (2021), PCPs are suggested to determine treatment planning as noted by generalized studies, influences by the AMA, and experiential factors. As noted earlier, Ajzen (2011), determined that social norms and peer pressures are considerations for behavioral outcomes.

Referring to Ajzen's research on beliefs (2011), the three components of beliefs in the trajectory toward behavioral decisions, are behavioral beliefs, normative beliefs, and control beliefs. According to Ajzen and Fischbein (2000), behavioral beliefs are viewpoints of other's expectations toward a behavior, or the impact of the decision. Jachimowicz et al. (2018) suggested that normative beliefs are the social pressures and the perception of others. Lastly, Müller (2019) examined control beliefs, noting self-efficacy or the amount of personal control on a behavior factor into decision-making. Understanding the trajectory of beliefs and attitudes, interjected with intentions, determines behavior as stated by Ajzen and Fischbein (2000). Beliefs, applied to social psychology or the medical field, must be understood, as posited by Jachimowicz et al. (2018), citing the significance of bias, perspectives toward social groups, as aging populations, are critical to quality care. Lauretani et al. (2020) concluded that beliefs of

PCPs toward geriatric patients affects diagnoses, treatments, and sustainability of quality care. In addition to attitudes and intentions, beliefs are determinants in factoring medical best practices for patients.

Overall, when deliberating on reasons for focusing on PCPs for this research, the rapid increase in aging population growth coupled with a deficiency in geriatricians, was a key component (Wilson et al., 2017). Frank et al., (2018) observed that factoring the 30-40% patient ratio of geriatrics in PCP clinics, best practices, ethical care, and greater awareness is essential. Also, Peterson et al., (2018) considered the significant polypharmacy with older adults, the overuse of prescriptive treatments, and the complexities of geriatrics, determining a greater focus on PCPs provides insight and awareness of key attitudes, beliefs, and actions toward care. Additionally, PCPs are conducting neurocognitive assessments determining forms of dementia as Alzheimer's (Mansbach et al., 2020). According to Cantor et al. (2017), neurocognitive assessments are provided to less than 40% of geriatric patients with a dementia diagnosis and noted by Low et al. (2019) misdiagnosis is highly prevalent.

Additional to the sociodemographic incline of aging populations, and reflections of best practices and knowledge of complex and comprehensive geriatric conditions, there must be ethical care adherence for geriatric patients as noted by (Wilson et al. (2017). Baldissera et al. (2019) remarked that ethical care is the amalgam of autonomy, justice, and beneficence, and PCPs are lacking in these areas. Best practices are consideration for each patient uniquely and for medical, mental, and environmental factors (Zhang et al., 2020). Lastly, understanding the reasoning behind PCPs behaviors

provided a framework for enhancing and improving geriatric practices, and providing the highest quality of care (Mustafa et al., 2020).

Attitudes, Beliefs, and Actions

Attitudes, beliefs, and actions, as noted prior, are precursors to forming behaviors (Ajzen & Fishbein, 2000). Albarracin and Shavitt (2018) posited attitudes are "evaluative responses", and evaluations are unique to everyone (Caliskan et al., 2018). Lincango-Naranjo et al. (2021) noted that attitudes and beliefs toward an action have a greater propensity for beneficence with positive outlooks. Additionally, Lincango-Naranjo et al. (2021) further concurred that physicians' attitude and beliefs direct diagnoses, treatments, and patient support. Furthermore, Phoosuwan and Lundberg (2020) posited that understanding physicians' attitudes toward care is critical for changing behaviors toward patient care. Mustafa et al. (2020) substantiated that physician attitudes and beliefs toward aging or age-related diseases as Alzheimer's are biases that must be addressed for best practices and enhanced care.

Understanding attitudes, beliefs, and actions toward aging provided insight for ethical care, creating enhanced treatment planning, and provide greater autonomy, justice, and beneficence toward patients (Giles et al., 2018). Furthermore, according to Giles et al. (2018), decision-making is shaped by attitudes and beliefs. Nowell et al. (2017) discussed the importance of beliefs and intentions of physicians toward the aging population with significant issues as sexuality. Aging bias may interfere with communication, care, and patient autonomy (Nowell et al., 2017). Lastly, Reeve et al.

(2018) considered physician attitudes toward patient treatments with prescriptions are significant determining deprescribing, and upholding patient autonomy.

Gaps in Literature

As noted earlier, although the literature presents a breadth of knowledge on physician's attitudes toward components of aging as communicating on key aging subjects as sexuality (Nowell et al., 2017), there is no research focusing on physician's attitudes toward geriatrics. As Reeve et al. (2018) noted, geriatric care is complex, and Zhang et al. (2020) concurred that physicians must consider enhanced treatments beyond prescriptions for best practices. Attitudes of physicians toward aging, according to Korkmaz-Aslan et al. (2017), is essential in factoring patient well-being and quality of life. Bhardwaj et al. (2020) noted the significance of physicians overprescribing to older adults positing the need for further understanding PCP attitudes and beliefs toward aging, treatment options, and long-term planning. Rhee and Rosenheck (2019) documented how prescriptive treatments, although being the normative PCP geriatric treatment option, lack geriatric knowledge and psychiatric background. Ultimately, exploring attitudes, beliefs, and intentions of PCPs toward geriatric care will provide insight into geriatric care for improving diagnoses, treatments, and planning.

Alternative Geriatric Treatments

Although PCPs providing geriatric care primarily implement prescriptive treatment planning, alternative geriatric treatments are prevalent and relevant for deprescribing, minimizing polypharmacy, and enhancing patient quality of life (Petersen et al., 2018). Asprino et al. (2017) noted that PCPs are not utilizing comprehensive

cognitive assessments with the intentions beyond options as medications. Additionally, Blaum et al. (2018) concurred, noting that patient autonomy is neglected with limited diagnostic pathways. Alternative therapeutic options as light therapy (Onega et al., 2018) or herbal remedies (Busetto et al., 2017) are effective with comprehensive treatment planning. Harrison et al. (2019) further explored comprehensive treatment for dementia with non-pharmaceutical options and integrative periodic geriatric assessments.

As noted by Blaum et al. (2018) and Elbi et al. (2020), pharmacological treatments are the primary geriatric options for PCPs however cognitive behavioral therapies are one example of an alternative. Integrative approaches of PCPs with other providers create new patient pathways for palliative care, ethical practices, and minimizing multiple medications (Greene et al., 2018). Kang et al. (2020) concluded a significant correlation with integrative approaches, alternative therapies, and comprehensive assessments are feasible over medications. Conclusively, Greene et al. (2018), Kang et al. (2020), and Pereira et al. (2019), posit the significance and need for deprescribing geriatric communities and integrating new approaches with alternative care.

Summary and Transition

In summary, this chapter reviewed the significance of exploring PCPs attitudes, beliefs, and actions toward geriatric care. The lack of geriatricians has prompted older adults to seek PCP geriatric support (Rhee & Rosenheck, 2019). Current aging population conditions as Alzheimer's and Parkinson's demands complex knowledge and understanding of medical determinations, and mental, and environmental components

(Kang et al., 2020). Da Rocha Rodrigues et al., (2019) stressed the importance of integrative assessments with providers as psychiatrists and alternative therapists as gerontologists. Complexities of aging and age-related issues require enhanced training and comprehensive approaches. PCPs' clinics are treating more than 30% geriatric patients and given the socio-dynamics of prescriptive overuse, falls, comorbidities, and behavioral conditions, awareness on PCP decision making is critical. Understanding PCP attitudes, beliefs, and actions toward geriatrics will provide awareness and insights toward limitations affecting diagnosis, treatment, and communication with patients. Additionally, exploring PCP attitudes will create opportunity for training, new pathways for patient approaches, and best practices. Etikan et al. (2016) notes the significance of addressing a social issue as aging population growth and overmedication. New approaches globally support integrative geriatric assessments, periodic reviews, and comprehensive provider support (Kang et al., 2020).

Ultimately, geriatric care is growing with the aging population rise. A generic qualitive study is appropriate for exploring attitudes and gaining insight to PCP behaviors to address geriatric care. Attitudes, beliefs, and intentions are precursors to actions and behaviors either benefiting or limiting decision making. PCPs are making critical decisions for geriatric patients affecting their quality of life. Ajzen (1985) posited that behaviors can be predicted by understanding an individuals' attitudes and beliefs. A theory framework as the Theory of Planned Behavior or the Theory of Reasoned Action establish a foundation for generic qualitative study surveys, questions, and thematic analysis for greater understanding. Aging population growth has increased PCP geriatric

patient loads and coupled with a rise of polypharmacy, Alzheimer's, and age-related conditions, exploring PCP behaviors is crucial for patient autonomy, justice, and beneficence.

In the next chapter, the methodology of this research will be detailed with the rationale and design incorporating TPB as the framework. Also, the role of the researcher is defined and considering I work deprescribing geriatric patients as well as providing alternative therapy, my biases and attitudes are considered. Credibility, trustworthiness, and validity is crucial and all elements as biases, structured questions, constructing thematic analysis, coding, and conceptualizing results are explained. Nuijten (2019) considered replicability a significant element for trustworthiness and credibility. Additionally, sampling procedures will be detailed as well as data collection, instrumentation, and analysis. Lastly, ethical consideration was apparent throughout the entire research process identifying safety, ethical care, IRB standards, ensured the highest in research standards.

Chapter 3: Research Method

Introduction

The purpose of this generic qualitative study was to discover PCPs attitudes, beliefs, and actions toward geriatric care and to develop the knowledge of PCPs' treatment decisions (Caliskan et al., 2018; Cunningham et al., 2019; Rhee & Rosenheck, 2019). The primary goal of this study was to gain a greater perspective of PCPs geriatric practices. Asprino et al. (2017) posited that more awareness of PCPs attitudes and beliefs toward geriatric care is needed, including how these impact PCPs' behavior for treatment planning. According to Kang et al. (2020), geriatric care is complex and demands a comprehensive approach for patient autonomy and a higher level of care. PCPs are treating most geriatric patients due to a deficit in geriatricians, and geriatric complexities often require a specialized approach (McKenzie et al., 2017). As the aging population increases, more older adults will need geriatric care and PCPs must create new patient treatment pathways for beneficence in care (Asprino et al., 2017).

In this chapter, I define the reasoning for this generic qualitative study approach and why it was appropriate for understanding the attitudes, beliefs, and actions of PCPs toward geriatric care. I explore the rationale and design of the study defining key concepts, historical support, and reasoning of best practices for implementing a generic qualitative study. Also, I provide insight into my role as a researcher and any biases addressed; bias awareness is relevant for credibility in research (Monks et al., 2017). Next, I detail the methodology, identifying the population sampled, justification of my sampling strategy, and the procedures necessary. Instrumentation incorporated, data

collection, and analysis processes are defined and establish reliability for the study (Mansbach et al., 2020); a detailed methodology supports replicability and trustworthiness (Cypress, 2017). Lastly, I discuss the ethical concerns addressed to meet IRB requirements.

Research Design and Rationale

This generic qualitative study was conducted to answer the research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions inclusive of prescriptive planning? Qualitative studies are a process of inquiry regarding a social phenomenon (Bernard, 2017). In this study, I explored the attitudes, beliefs, and actions of PCPs regarding geriatrics. Understanding the preemptive feelings and thoughts that determine PCP behaviors can highlight insights into diagnoses, treatments, and communications for long-term planning (Bosnjak et al., 2020). As noted by Ajzen (2002), PCPs behavioral actions are shaped by positive or negative attitudes, learned beliefs, and behavioral control. According to Bradshaw et al. (2017), generic qualitative studies are theoretical inquiries of a social condition or phenomenon that are based on descriptive experience. A generic qualitative study paradigm was best implemented in this study exploring behavior of PCPs (Ajzen, 1985; Basnjak et al., 2020). The phenomenon of PCPs attitudes, beliefs, and actions toward geriatric care were approached with open-ended questions exploring key concepts (Arevalo & Brown, 2019).

Thirty-five percent of pharmaceutical-related traumatic injuries in the United States occur among the geriatric population, including fall injuries; this population experiences 50% of health-related issues and 40% or greater of fatalities (Mackenzie et

al., 2017; Schick et al., 2018). Polypharmacy, concomitant use of more than five psychotropic medications, is present in 95% of all adults aged 65 years and older (Aypak et al., 2016). Geriatric patients are prone to secondary medical issues with increased prescriptions due to opioid use prescribed by PCPs (Pereira et al., 2019). In addition, inappropriate opioid prescriptions cause significant secondary conditions such as insomnia, falls, morbidity, or hospitalization for institutionalized older adults in addition to substance misuse (Daoust et al., 2018). Overall, prescriptions issued by PCPs are routine treatment planning for geriatric patients (Tarn & Schwartz, 2020).

PCPs continue to prescribe psychotropic medications, like benzodiazepine, to 53% of geriatrics patients with Alzheimer's (Kerns et al., 2018). In addition to polypharmacy, older adults are assessed and diagnosed with dementia or Alzheimer's by PCPs, altering treatment planning, and further adding to patient prescriptions (Petrazzuoli et al., 2017). According to Fischer et al. (2017), Alzheimer's geriatric injuries are further burdened by polypharmacy and cognitive decline connectivity. Psychological or psychiatric professional Alzheimer's diagnosis collaboration is needed to prevent misdiagnosis, which determines treatment planning (Fowler et al., 2020; James et al., 2020). More than 25% of Alzheimer's diagnoses are false, and such diagnoses determine prescriptive treatments, housing, and care planning (Bertrand et al., 2017). Comprehensive geriatric care requires psychological and behavioral expertise (Bertrand et al., 2017). Bernstein et al., (2019) determined that only 13% of PCPs are confident in determining a neurocognitive disorder such as Alzheimer's disease.

Although polypharmacy and misdiagnosis of neurocognitive disorders are prevalent among PCPs geriatric practices, morbidities and early mortalities continue for the aging demographic (Bertrand et al., 2017; Fowler et al., 2020). Comprehension of neurocognitive disorders, such as Alzheimer's, extend beyond medical needs to an integrative psychological, sociodemographic, and behavioral stance (Vellas & Morley, 2018). Vellas and Morley (2018) and Little and van der Flier (2017) viewed diagnostic treatment and care of geriatric patients as a comprehensive effort with extensive geriatric education and understanding. Although geriatric expertise is needed, the aging population exceeds geriatrician availability, leaving PCPs to treat older adults (Lester et al., 2020). Comprehensive geriatric care for pre-Alzheimer's patients requires diagnostic integration other than PCPs assessing Alzheimer's (Black et al., 2020). Additionally, Black et al. (2020) established that 57.1% of Australia's PCPs refer patients for geriatric assessment, affirming the need for integration of medical, mental, and sociodemographic care.

Comprehensive geriatric care is complex and facing a crisis because of growth in the aging population and limited geriatric expertise (Lester et al., 2020; Shah et al., 2016). PCPs general practice is comprised of 30% to 40% geriatric patients, approximately 17 million adults, nationwide (Frank et al., 2018). Blaum et al. (2018) concluded that person-centered health care for geriatric patients must be paired with standards for cognitive assessments, treatment planning, and care. Additionally, Fischer et al. (2017) concurred with comprehensive geriatric consultations as psychoses often are interpreted as mild cognitive impairments. Misdiagnosis often occurs as psychological or behavioral healthcare is not consulted with medical treatments (Bhardwaj et al., 2020;

James et al., 2020). According to Bernstein et al. (2019), geriatric issues, such as polypharmacy and misdiagnosis, provide a basis for further research understanding the duress placed on PCPs. Understanding the attitudes, beliefs, and actions of PCPs would allow for greater insight into geriatric practices (Bernstein et al., 2019; Leung et al., 2018).

Although research into PCPs treating geriatric populations has led to important findings, I have found no research conducted to examine PCPs attitudes, beliefs, and actions toward geriatric patients and the impact on treatment decisions. Prescriptive behaviors are impacted by an understanding aging and age-related issues and concrete knowledge (Rossi et al., 2020). Furthermore, Rossi et al. (2020) posited significant influence of multimorbidity and poly-pharmaceutical treatments causing secondary physical and mental conditions (Ketokivi & Choi, 2014).

Inquiry into PCPs behaviors is relevant and plausible through a generic qualitative study methodology; the geriatric population growth is exceeding expert geriatrician care (Caliskan et al., 2018). Contextualizing key concepts within the generic qualitative study approach provided empirical descriptions of the current phenomena of PCPs attitudes, beliefs, and actions toward geriatric care (Arevalo & Brown, 2019). Rather than using closed-ended questions in a survey, this generic qualitative study allowed for inquiry into unforeseen concepts and provided opportunity for new insights (Fleming et al., 2017). Systematically and methodologically analyzing and defining key concepts, themes, and insights of the PCPs behavioral intentions toward geriatric care provide a significant relevance in society, even with a small sample size (Arevalo & Brown, 2019). Using a

sampling of PCPs will ensure rich data are obtained and support research trustworthiness (Clark & Vealé, 2018; Cypress, 2017). Generic qualitative studies are inductive and aid a researcher into further exploration of a particular social phenomenon (Moser & Korstjens, 2018; Liu, 2016).

Although a generic qualitative study approach was used, I examined alternative approaches, ensuring consideration for all methodologies. Phenomenology, grounded theory, and ethnography were a few approaches considered before a generic qualitative study was determined the best suited for exploring PCPs attitudes, beliefs, and actions toward geriatric care (Caliskan et al., 2018). Understanding the right framework provided answers for my research question. Several approaches were reviewed and evaluated; however, a generic qualitative study methodology provided the platform for exploration and insight (Rahi, 2017). Each qualitative approach provides a unique characteristic (Rahi, 2017); based on theoretical framework used and research question, a generic qualitative study remained the viable option for this study.

The phenomenological approach is used to explore a person's or a group's experiences with descriptive analysis (Alase, 2017). This approach is focused on in-depth understanding of an experience with complexities measurable incrementally (Miller et al., 2018). My study did seek to understand experiences but was focused more on abstract feelings and thoughts not definable by a researcher. Humanities or the arts are areas aligned with phenomenology (Rahi, 2017). Measurable concepts, such as attitudes or beliefs, are best examined with quantitative phenomenological research rather than qualitative (Schaefer et al., 2020). Again, in this research, I am exploring attitudes,

beliefs, and actions that are unique and varied rather than quantifiable; the qualitative approach is descriptive (Rumman & Alheet, 2019).

Another approach is grounded theory, which is used to create a hypothesis surrounding a social condition with complex methodological systems (Chun et al., 2019). Although I used purposive sampling of PCPs, grounded theory incorporates rather theoretical sampling as data collection progresses (Breckenridge & Jones, 2009). A generic qualitative study allowed for a more descriptive analysis, or contextualization, although grounded theory focuses on finding a theory that emerges from the data (Moser & Korstjens, 2018). Percy et al. (2015) noted that generic qualitative study methodology is focused primarily on analysis rather than extensive data collection and rigor, such as in grounded theory, and for this study, brevity was necessary.

I considered ethnography for this study as well, given I am interested in a particular group of PCPs (Jones & Smith, 2017). An ethnographic study is used to observe a group in a natural setting for a descriptive narrative (Hammersley, 2018). However, due to privacy and confidentiality guidelines, this option was not viable. This generic study provided an opportunity for PCPs to share their own narratives on attitudes, beliefs, and actions toward geriatric care, which was essential to answering the research question (Branion-Calles et al., 2019).

Role of the Researcher

As a researcher, my role was to bring my qualitative skillset to this study providing a confidential interview forum for PCPs and analyzing the data with integrity (Surmiak, 2018). Merriam (1998) noted that the "researcher is the main instrument"

collecting data, analyzing, and interpreting with integrity. Additionally, replicable, and detailed methods were critical minimizing bias and ensuring reliability and validity (Bergen & Labonté, 2020). Providing descriptions of my role, addressing any biases and how they will be managed, and presenting my methodology were explained in this paper (Monks et al., 2017). It was my role to answer the research question and present findings, unbiased, and with empirical research knowledge meeting APA standards (Monks et al., 2017).

I am a gerontologist focusing on ethical care and human rights for older adults and geriatric patients that are experiencing cognitive decline. My patient treatment planning focuses on deprescribing psychotropic drugs and presenting alternative therapies. Considering my bias toward overmedicating older adults, I adhered to strict research measures ensuring that I was objective and sensitive to PCPs (Hoffman et al., 2019). My background in scholarly research is primarily during my academia however my neuroscience research education prepared me for all aspects of research. In addition to my academic knowledge and experience, I had the oversight of my doctoral committee, and the Institutional Review Board. Ensuring that my research had no bias in verbiage, procedure, or analysis, a thorough review by the IRB and my committee ensured trustworthiness (Nowell et al., 2017).

Methodology

Sampling

The population focus for this study was PCPs that treat geriatric patients in their clinics. Oregon currently has approximately 1,500 PCPs that have a 30-40% geriatric

patient base (Frank et al., 2018). Participant demographics provide a diversity of age, race, culture, and gender. Given the PCP population was specifically chosen for this research, this study utilized purposive sampling (Etikan et al., 2016). PCPs are general practitioners that treat patients from infancy to geriatrics (Barnes et al., 2018). All PCPs were members of the American Medical Association currently practicing in Oregon. Estimated participant size was nine PCPs which currently treat geriatric patients (Hennink et al., 2019). According to Hennink et al. (2019), themes and coding begins repeating throughout each participant until a common understanding (s) are achieved.

The research question for this study focused on a particular group with a specific focus and purposive sampling was the best sampling method (Etikan et al., 2016). Purposive sampling as noted by Etikan et al. (2016), is the "deliberate" selection of participants that meet a particular attribute needed for the study. Unlike random sampling, purposive sampling was focused on a certain population (Bernard, 2017). Bernard (2017) and Etikan et al. (2016) concur that deliberate sampling selection is conductive to meet the "phenomena of interest".

Recruitment

For this study, I placed a recruitment advertisement for primary care providers through social media and Facebook page of Oregon Physicians. As a Facebook member, I did not have to pay for the advertisement. Additionally, I contacted Oregon clinics asking to submit my recruitment advertisement via email, as per IRB approval. The advertisement addressed the doctoral research need for PCPs for a brief interview.

Selection of PCPs were chosen based on the first responses to the advertisement via social media platform (see appendix with recruitment advertisement).

Instrumentation

This generic qualitative study focused on exploring the attitudes, beliefs, and actions of PCPs toward geriatric care adding depth to understanding their care practices. Utilizing interview questions based on the Theory of Planned Behavior framework, I interviewed nine physicians which completed open-ended interview questions. Percy et al. (2015) posited that generic qualitative studies allow a researcher to focus on a unique interpretation, as attitudes, that create meaning in a social phenomenon. For my study, phone, or video interviews with physicians, utilizing open-ended questions, were the instrumentation. Each interviewer was given an assigned letter and number to confidentiality.

Data Collection

Qualitative data were collected via interview questions based on Ajzen's theory of planned behavior question construction with directed behavioral considerations (Ajzen, 1985) (See appendix). Scripted questions based on TPB framework was constructed in sections based on behavioral beliefs, normative beliefs, and control beliefs (2011). According to Ajzen (1985), beliefs, attitudes, and actions, were the foundations of behavior, and the interview questions informed on positive or negative correlations.

I transcribed the questionnaire responses from either phone interviews via Voice Memo or from Zoom software. Voice Memo is a secure phone recording application that was saved directly to my private computer and transcribed. I then uploaded the

transcriptions to MAXQDA 2020 and code via the software capabilities highlighting key terms and phrases. Also, I l transcribed Zoom interviews securely via my private computer and uploaded to Microsoft Excel. Microsoft Excel is a secure application that provided a platform for coding, thematic analysis, and organization. A practical platform tool, Microsoft Excel provided transcription support for descriptive analysis. As this generic qualitative study explored sensitive topics, confidentiality of PCPs was critical with interviews and coding, and ethical consideration was imperative (Hennink et al. (2019). Collection of data and analysis defined themes, emergent concepts, and triangulation implemented for validity on the small sampling of PCPs. I used priori coding in accordance with Ajzen's (1985) Theory of Planned Behavior categorical transcription supporting behavioral components. I then coded, and sorted by attitudes, beliefs, and actions as per the Theory of Planned Behavior for a thematic analysis (Salmani et al., 2020).

Trustworthiness

Credibility

According to Percy et al. (2015) accuracy and internal validity were achieved by transparency with established methodology, collected information, and analysis. Wood et al. (2020) noted the importance of credibility to trustworthiness in generic qualitative research displaying findings transparently and methodologically. This research-maintained consistency with data collection processes and replicable transcription practices with telephone recordings, Zoom video interviews, and Excel coding (Wood et al., 2020). Additionally, my rapport remained objective and consistent in my manner and

tone remaining unbiased in demeanor. According to Liao and Hitchcock (2018), consistent coding, theme analysis, and finding interpretation relay credibility. Lastly, member-checking with participants provided continuum and clarity with transcription for credibility (Wood et al., 2020).

Transferability

Daniel (2019) posited that transferability is achieved via clear findings, transcriptions, conveyance of results. Generalizability of findings and a study that is applicable to current social conditions results in transferability (Wood et al., 2020; Yin, 2010). My study findings were aligned with fields as gerontology, mental health, and medical exhibiting transferability (Wood et al., 2020).

Dependability

Documentation with all stages of my study provided dependability beginning with interviewing structures, consistently utilizing transcribing, and coding software, and seeking accuracy with documentation (Moser & Korstjens, 2018). Documentation allowed for researcher critique and replicability in the field of study (Percy et al., 2015). Additionally, thorough review of all transcriptions, notes, and coding, provided accuracy and minimized researcher bias, as well as committee review (Nowell et al., 2017).

Confirmability

Korstjens and Moser (2018) noted that confirmability allows other researchers to corroborate and substantiate the research. Minimizing researcher bias, as noted earlier, was achieved with transparency in methodology, uniformity of questions, coding, and analysis measures for replicability (Korstjens & Moser, 2018). Interpreting interviews

and consistently analyzing transcriptions and codes allows for confirmability reducing researcher bias and voice (Fusch et al., 2018). The forms to reduce bias were member checking, reflexive journaling, peer review, and committee review (Fusch et al., 2018).

Ethical Procedures

Ethical procedures of this study were reviewed with the Institutional Review Board and validated by a research number after approval. Ensuring ethical standards were apparent throughout my study. Physician participation of this study was only on a volunteer basis and all participants received a confidentiality form included with a participation consent form (see appendix). Each participant selected did not have a personal or professional relationship with me as to minimize bias. The Institutional Review Board guidelines and standards were observed in my study and ethical behaviors with participants were strictly observed. Participants were of diverse age groups, race, culture, and ethnicity. Also, each participant name will be confidential and remain anonymous and giving letters and numbers accordingly. According to Moser and Korstjens (2018), transparency with participants is imperative for upholding ethical standards and within my study, each participant received a detailed description of the study, nature of study, and received transcription to ensure intention. Lastly, each stage of the study was strictly confidential and observed IRB standards with protected data, password applications, and coding anonymously. This study ensured all participants and interviews did not pose risk or harm, all study methods were transparent, and finally, participants had the option to rescind participation (Bradshaw et al., 2017; Kahlke, 2018)

Summary

In this methodology chapter, a detail of purpose was reiterated describing the research question and purposed questionnaire aligned with the Theory of Planned Behavior. Understanding the rationale of the study, the interview process, and applications for recording interviews and coding analysis, were examined and detailed. Also, addressing any researcher bias was reviewed with methodology, transparency of processes, and Institutional Review Board standards. Instrumentation was explained with questionnaire details, transcription processes, coding software and transcription. Participants were given details of the study and final transcription notes for intention alignment. Additionally, trustworthiness was detailed in this chapter aligning credibility, reliability, and confirmability, ensuring ethical standards and integrity (Moser & Korstjens, 2018; Percy et al., 2015). Transferability and generalizability were examined showing relevancy in the field and appropriate current social application. In chapter 4, the results of the study were detailed showing emerging themes, nuances, and interpretation of participant interviews.

Chapter 4: Results of the Study

Introduction

The purpose of this generic qualitative study was to explore PCPs attitudes, beliefs, and actions toward geriatrics and to expand understanding of PCPs geriatric treatment decisions (Cunningham et al., 2019; Rhee & Rosenheck, 2019). The goal of this generic qualitative study was to gain a greater understanding of geriatric care among PCPs practices in relation to geriatric patient treatments. This generic qualitative study was conducted to explore mitigating factors of PCP behaviors impacting geriatric care. This research was guided by the following research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions?

Chapter 4 includes an introduction and overview of the purpose, a description of the methodologies conveying effectiveness, and the results of the explorative qualitative study. The setting and demographics of the study are detailed, showing the interview process, data collection, and thematic analysis. I also describe the coding process and categorization and the emergence of themes and provide direct participant quotes as examples. Evidence of trustworthiness is presented including explaining what steps were taken to ensure credibility, transferability, dependability, and confirmability. Also, in this chapter, I provide details of the interview timeframe and frequency and any deviations from the original plan. Lastly, I present the overall results of the research.

Setting of the Study

Upon receiving IRB approval (# 08-13-21-0675860), I began my recruitment process. The participants were PCPs currently practicing in the state of Oregon.

Participant interviews were conducted at a convenient day and time for the physicians' schedules via Zoom using video or phone. The interviews were conducted privately in a quiet room and audio was captured with Voice Memos. Zoom, video and phone, interviews allowed the participants to answer questions candidly in a private setting (Gray et al., 2020).

Demographics

Nine participants completed the semi structured interviews via video or phone. The participants were all practicing PCPs across the state of Oregon with a geriatric patient base. Five PCPs were from rural counties and four practice within city limits. All nine physicians had been practicing with geriatric patients for more than 17 years. Five PCPs agreed to Zoom video interviews and four to phone interviews.

Data Collection

I interviewed nine participants, PCPs, from the state of Oregon. Aligning with IRB approval, I contacted Oregon clinics across the state via phone and asked if I could email my recruitment posting to their clinic. I stated my role as a doctoral student. For 2 weeks, I phoned 116 clinics across Oregon. Eleven PCPs responded via email, but one did not meet the criteria of PCP and another physician declined to be interviewed. Three clinic managers emailed me stating the clinic physicians were not interested in participating in the study.

After noting participant qualifications, I emailed the consent form to the physicians, and all nine participants responded "I consent" via email. Correspondence was completed via email to schedule interview days and times with Zoom video links

attached. The audio recording was captured with the Voice Memo application, and I transcribed the data into a Microsoft Word document using the application's dictate feature. All recordings and transcriptions were stored with password protection in a computer folder. All data collection processes aligned with those discussed in Chapter 3, and no deviations were noted.

In preparation for interviews, I practiced asking questions in the mirror, noting my intonations and expressions to minimalize my impact or emphasis on questioning. My experience with prior research studies allowed me to maintain a calm presence to not entertain researcher bias. The interview questions were developed in alignment with theory and the research question. Each interview was conducted in the privacy of my home office, and the participants chose a private location. With each interview, I spoke clearly and did not need to rephrase or clarify the questions presented. My questions were open-ended, allowing physicians the opportunity to answer at their own discretion and candidly. The interview durations ranged from 20 to 30 minutes. Participants presented openness and candor. The recruitment and interview process were conducted within 30 days.

Upon completion of each interview, I thanked each participant and reminded them that a transcript from their interview would be sent to them for acceptance. If the transcript did not capture their answers correctly, they were invited to note the differences. All nine, after receiving their transcripts, returned an email stating, "I accept." I also sent a thank-you email to each participant and a handwritten thank-you card.

Hennink et al. (2019) posited that data saturation is evident when recurrent themes are noted in the data collection process. In my study, data saturation occurred with six participants, and I continued with three more to ensure rich data and further detailed descriptions. Generic qualitative studies can reach saturation with smaller sample sizes when new participants no longer provide no new themes (Smeets et al., 2019). My intent was 10 participants; however, nine participants provided robust data. As the participants answered questions, I prompted for further exploration as needed to enhance the depth and expression of the answers. I was confident with the sample size and data saturation achieved.

Data Analysis

All transcripts were entered in Microsoft Excel and were manually coded and categorized using thematic analysis (Clark & Vealé, 2018; see Appendix A). I entered the data in a linear fashion across the rows and columns, I read the answers multiple times ensuring understanding, and I highlighted keywords and phrases using an iterative coding approach (Lawless & Chen, 2019; Nowell et al., 2017). Given this was an inductive study, exploring themes were presented with open-ended questions (Moser & Korstjens, 2018). I used multiple Excel tabs for each question with corresponding answers, highlighting words and phrases, line by line, analyzing all the data for key codes. After exhaustive highlighting, I merged the codes into six overarching categories. Each of these categories were color coded for key wording and categories.

After six categories emerged, I then went back to the highlighted words and phrases developing the supporting overarching themes. With each color-coded category, I

copied direct quotes to be organized under each category for support. Often the codes were similar, but I narrowed the concepts down to the six categories. These six categories exemplified the key concepts across all participants' answers (see Table 1): (a) patient care, (b) geriatric training, (c) polypharmacy, (d) aging complexities, (e) comprehensive care, and (f) Medicare.

After coding and categorization, emergent themes were organized under each category, as noted, ensuring a significant analysis process for trustworthiness (Korstjens & Moser, 2018). Each of these measures during the analysis process ensured credibility, transferability, and reliability (Korstjens & Moser, 2018).

Table 1

Categorization of Codes

Codes and Themes Categorized

	Training	Patient Care	Polypharmacy	Integrative Care
Patient Care	Interventions and Treatments	Enjoy Geriatric Patients	Continuum of Care	Patient relationships
Training	Medical School Courses	Experience from Former Practice Physicians	Geriatric Complexities	Medications and Alzheimer's
Polypharmacy	Medication Interaction	Medication Management	Comorbidities and medication	Need for Pharmacist Integration
Complexities	Alzheimer's Disease	Comorbidities	Family Support	Social Services
Comprehensive	Nursing Home Relationship	Team Based Approach	Family and Community Support Structure	Need for Mental Health Professionals
Medicare	Limitations on Available Services	Lacking medical Access for Geriatric Patients	Medicare A&B Unacceptable Insurance	Inability to Provide Patient Care

Evidence of Trustworthiness

Credibility

In my study, trustworthiness and validity were accomplished by triangulation using the same sources, questions, and methods with data collection from each participant (Arevalo & Brown, 2019). According to Arevalo and Brown (2019) accuracy and internal validity are achieved through transparency with established methodology, collected information, and analysis. Wood et al. (2020) noted the importance of credibility to trustworthiness in generic qualitative research, displaying findings transparently and methodologically. This research was consistent in data collection processes and replicable transcription practices with telephone recordings, Zoom video interviews, and Excel coding (Wood et al., 2020). Additionally, my rapport and tone remained unbiased.

According to Liao and Hitchcock (2018), consistent coding, theme analysis, and finding interpretation relay credibility. Across all participants, I coded and categorized each question ensuring consistency with data analysis. Lastly, member checking with participants provided continuum and clarity with transcription for credibility (Wood et al., 2020). Participants were sent their transcripts to check for errors or inconsistencies with their answers.

Transferability

Daniel (2019) posited that transferability is achieved via clear findings, transcriptions, and conveyance of results. The generalizability of findings and study applies to current social conditions result in transferability (Wood et al., 2020). The findings aligned with fields such as gerontology, mental health, and medical, exhibiting transferability (Wood et al., 2020). This study resulted in meaningful and rich information applicable to gerontology, mental health, and the medical community. Each interview was recorded similarly with Voice Memo and Microsoft Word dictation for consistency. Each transcription was labeled and detailed similarly, ensuring uniformity. I practiced uniformity with each participant by asking questions and allowing sufficient pauses for participant reflection and answering. Each phase of this study is replicable due to the transparency and clarity of each step.

Dependability

Documentation with all stages of my study provided dependability, beginning with interviewing structures. I consistently used transcribing and coding applications and sought accuracy with documentation and replicability (Moser & Korstjens, 2018).

Additionally, a thorough review of all transcriptions, notes, and coding, provided accuracy and minimized any researcher bias, as well as final committee review (Nowell et al., 2017).

Confirmability

Korstjens and Moser (2018) noted that confirmability allows other researchers to corroborate and substantiate the research. Minimizing researcher bias, as noted earlier, is achieved with transparency in methodology and uniformity of questions, coding, and analysis measures for replicability (Korstjens & Moser, 2018). I used triangulation as an approach for confirmability of the study. I interpreted the interviews and consistently analyzed transcriptions and coding for confirmability to minimize any researcher bias (Fusch et al., 2018).

Results of the Study

The study consisted of 11 questions created in alignment with both TPB and the research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions? All nine participants were asked the same questions and all nine answered 11 questions. During the data analysis, five predominant themes emerged: (a) limitations of geriatric patient care due to Medicare restrictions, (b) the need for a greater comprehensive and integrative approach with mental and social services, (c) understanding polypharmacy and medication interactions and incorporation of pharmacists, (d) and barriers to patient care due to limitations of family support with social and environmental factors, and (e) the joy and fulfillment of treating geriatric

patients. PCPs attitudes and beliefs toward geriatric care culminated in these five themes and are supported in the following section.

Theme 1: Limitations of Geriatric Patient Care Due to Medicare Restrictions

The first emergent theme developed consistently across all nine participants indicated the limitations of geriatric patient care due to the parameters of Medicare lacking audiology, dentistry, and ophthalmology treatment services. PCPs revealed areas of patient care that were barriers impacting the quality of life for their geriatric patients. The Medicare annual wellness program, for example, require physicians to detail needed care however limitations prevent certain medications and services from being authorized.

Medicare Insurance Barriers to Needed Services and Specialties

The participant responses supported this first theme and denoted how all nine felt a negative attitude toward Medicare insurance. Participant A26 noted:

> I think one thing, to be totally honest, and this is nothing that anybody can change, or anyone locally can change, but a lot of my geriatric patients only have Medicare Part A&B insurance, and it is such terrible insurance coverage. My low-income geriatric patients, they don't have any prescription insurance coverage, or they may have very high co-pays to go see a specialist and simply they don't go. And, so, I think that if Medicare were better insurance that would make things easier. The manual of Medicare has a required template for the annual wellness visit, so I go through the whole template and one of the questions of course on there is like "do you have any problems with your hearing?" and I would like to make a referral to audiology. I can offer people referrals to audiology until I'm

> blue in the face, but I can tell them, "Oh you have a hard time hearing?" and they didn't say "yeah I'd like hearing aids," but if their Medicare doesn't cover hearing aids, so it's like, even if they did pay the $45 to the company to go see the audiologist, their insurance doesn't cover the hearing aids; they can't afford hearing aids. They still can't hear and so sometimes I get frustrated with the Medicare annual wellness visit.

Navigating Medicare for Appointments and Medications

Denoting the limitations of Medicare and the barriers to quality geriatric patient care, A23 concurred stating barriers to scheduling appointments with both PCP and specialists:

> I have about 25% Medicare patients and that's because people are so frustrated with modern medicine and not being able to talk to their physicians and taking 16 weeks to get in to see them. They call and it takes them a week to hear back from them and people are really frustrated with that, and they feel like they're at a time in their life where their health is most important, and they want to be able to have a relationship with a physician.

Continuing, A23 relayed the cost of needed medications and quality of treatment options:

> I would say absolutely that Medicare has an impact because nowadays it all depends on what medications are on their plan and what they can afford. It may not be the best medicine it may not even be the second-best medicine, but we are having to use the third or fourth medicine for something because we are limited by their Medicare. And what they can cost.

A22 concurred, noting "so, a lot of the things that we get prescribed when they turn 65 with Medicare are not appropriate for them." The frustration with Medicare was repeated across all nine PCPs stating limitations of services and medications covered. A24 noted:

> It is ridiculous that we must talk to people about hearing difficulties right, like we screen people for hearing difficulties, but then I know that Medicare is not going to cover the cost of hearing aids. So that is there's a large percentage of my population that is just like "well so I guess I'll just be deaf because I can't afford" and so these are things that I think about a lot that are very frustrating.

The remaining participants also stated their negative viewpoints toward Medicare. Participants indicated obstacles to quality geriatric patient care as A23 noted "Some people are really limited on what they can take medicine wise, because of Medicare".

Nursing Home Limitations with Medicare Insurance

In addition to limitations on Medicare for services and medications within the PCP practice, eight participants mentioned barriers to obtaining the same services and medication in nursing home care, as A27:

> Placing people in higher levels of care, basically it is kind of like what my nurse case manager does but somebody specifically for insurance is who can help us with placement into assisted living and nursing homes and helping us with the insurance aspect of it, that would be amazing.; not something that would ever happen but that would be amazing.

According to all PCPs, Medicare diminished their ability in their practice and nursing homes, to properly treat geriatric patients with services needed, proper

medications that minimized side effects or interactions with other medications, and even establishing appointments for specialists. PCPs attitudes toward geriatric care indicated "frustration" and resignation knowing their patients would not receive the care need.

Theme 2: Greater Comprehensive and Integrative Approach

This second theme emerged as participants recognized obstacles to a comprehensive approach to geriatric patient care inclusive of social workers, psychologists, and pharmacists. Geriatric care complexities as Alzheimer's, require a team of expertise and support for navigating insurance, as noted earlier, obtaining homecare services, providing neurological assessments, and navigating age-related issues.

Burden of Care Resides with Primary Care Physicians

Seven PCPs noted that integrative care was limited, and most of the care relied singularly on them. A22 stated:

> Distinctly in my practice, my practice has been around for a very long time considering most general practices. And, so, we have well-established care with people and oftentimes those relationships were established with our elder population when they were younger. We've kind of grown as a practice with our patients. Now, I mean specifically, obviously we have younger providers there now. We have sort of this wealth of information on our older patients with them coming through our practice over many years. Also, we are in an area that has a ton of independent living facilities and nursing facilities right around us, so we have good access to those facilities. Often their children or their grandchildren are

> also patients in our practice so there is really good relationship with the families. I think that medicine is confusing, and the older we get, it does become harder and harder to keep track of our health our treatment options. Just having family support, community support is essential.

A29 concurred, noting the time and staff involvement without comprehensive care teams:

> That's a weakness. I would say of being an independent small physician is that I don't have a lot of help with other things, so my staff and I handle a lot of things on our own. Then we look out for whatever other resources are available that we don't have. Like, I don't have anyone else in any other services in the office with me so that's one disadvantage. Other local physicians help cover my practice and we cover for each other and we're on call for each other.

Without specialists as social workers and mental health professionals, PCPs are limited in additional support and time for geriatric patients. A26 remarked:

> Again, we don't have as many social workers, we don't we have RN care coordinators, so I would love to have more of like a team approach toward geriatric patients. I do think that we do the best that we can, and our medical assistants get to know our geriatric patients well and often are good resource for them.

Limited Resources for Basic Needs and Outside Support Services

Additionally, A26 continued that even outside services for basic needs are not always available:

> But our medical assistants do a good job of doing like fall screening, they do a lot of outreach phone calls for us but otherwise we don't have a lot of kind of program services, interdisciplinary services, I think our patients would really benefit from. And, in terms of working with community organizations, I would love to do more of that but partly I don't totally know what they are and partly I think that they are already really stretched than themselves.

A22 also concurred the need for ancillary staff and integrative care teams for geriatric patients "The biggest limitation I think, some patients don't have the flexibility of some of the bigger clinics that have more variety of ancillary staff that could be helpful".

Geriatric patient care is complex and the need for mental, social, and behavioral health care is essential according to A24: "I do think it having somebody who specializes like gerontologist that is extremely beneficial just because there's so many different issues polypharmacy, all kinds of other things that exist that affect elders differently."

Also, A26 noted the need for the staff to do social service work to care for their geriatric patients as there is not a social worker or mental health care provider:

> I sometimes, for example for like mental health stuff, I've utilized the clinic, which is a great kind of like urgent care feel for mental health stuff, and it's a great service but they also have really limited access then everybody is stretched so thin then we end up doing neither and patients don't get the services, or we do stuff kind of on our own.

A25 expressed concern for providing resources to geriatric patients and the need for access to specialists for mental health and social services:

> I think that geriatric care can be complicated for a couple reasons. That's a wide question. Geriatric care is real and there are truly old people out there it's not a conspiracy. I think it is probably somewhat an underserved population. It can be difficult to get a lot of people in nursing homes and many can't get to doctors. They don't have the technology now that we're doing virtual visits and a lot of them have trouble operating a cell phone or the don't have laptop, so I think there are some barriers to it. Even by nature of busy practices, they take the most time, so I think they don't get as much attention because it just takes too long, so I think it takes a special person to spend time with them. I guess that's why they have geriatric specialists. Resources Available Within Health System Practices

Seven of the nine participants worked in smaller practices, both within city limits and rural communities, and lacked access to services, equipment, and specialists, due to insurance parameters and proximity to services. Even with membership-based practices, limitations occurred accessing specialists. Two PCPs are integrated into a health system practice and have in-house mental health providers, social workers, and specialty services easily accessible to geriatric patients. Additionally, access is comprehensive and within a similar medical records system. As a Health System practitioner, A23 explained:

> I see my elderly patients on a regular basis and usually see them at least at least every three months, even if they're healthy or without any problems. If they do have ongoing medical problems, I see them back every six weeks and my comprehensive care is really participating within their care, monitoring things

> closely. If I do have to use other outpatient services like mental health or specialists, I work with them closely in caring for these patients.

Although A24, noted "we actually don't have access to good mental health that is kind of something that is not so great", overall comprehensive care is accessible:

> So, since we're a health system, part of the health system, we do have good access to specialists, and we are able to communicate well with different specialties. So that's always nice to have just even if there's a question, even if we had patients that aren't seen by those providers, and there is pretty good communication. We also have good physical therapy in the area that is good with working on people for pain and balance, and mobility issues. There is good access to home health.

Theme 3: Understanding Polypharmacy and Medication Interactions

A third theme emerged as all nine participants noted complexities of geriatric care due to medication interactions and polypharmacy. Polypharmacy is the phenomenon of patients prescribed more than five medications. Polypharmacy can be untraceable due to limitations of multiple medical records systems to which PCPs do not have access as noted by A21 "For me, it would probably be having access to a shared medical record system or share DMR". Additionally, A24 noted the need for greater understanding of polypharmacy and access to pharmacists:

> I would, I think, I wish I really have a better understanding of polypharmacy. I think that is one of the biggest disservices that sort of happens with our elderly population. It is so easy to just keep adding medications and not really paying attention or even understanding how things are interacting. And that can lead so

> many issues. So, I really wish that I had it better foundation and understanding and ways to approach that. I think that in some way that's unavoidable, but I do think that there are ways to make it better. I don't know what they are.

A27 added: "Polypharmacy is a big issue more than dementia mobility issues like I mentioned, heart disease, diabetes, high blood pressure, yeah those are the main ones." Integrative and comprehensive care to manage polypharmacy would be the inclusion of pharmacists in geriatric care. A29 noted:

> I think I had a lack of knowledge about geriatric care and polypharmacy. I think I've learned a lot in my 17 years in practice about geriatric care and so and I've sought out extra training at conferences and things like that. So that has been helpful but that was initially a drawback take a lack of training and on my part.

Geriatric patients have complex issues as Alzheimer's and prescriptive management is critical for medical and mental health issues. All participants stated importance of medication management for polypharmacy issues as well as minimizing secondary issues impacting patients with Alzheimer's. A23 shared "I mean I would love for them to be able to have more resources you know medication and mental health".

Also, pharmacists would aid in medication management and knowledge coordinating with Medicare for best practices of geriatric care, as A23 added:

> I would say absolutely that Medicare has an impact because nowadays it all depends on what medications are on their plan and what they can afford. It may not be the best medicine it may not even be the second-best medicine, but we are

> having to use the third or fourth medicine for something because we are limited by their Medicare. And what they can cost.

A29 shared of a recent patient case that would have benefitted from a pharmacist team: "I thought of a case just the other day where there was this big snafu in medication orders that I sent over for a patient and they did not get the care that they needed".

A21 noted the need for pharmaceutical knowledge as part of the primary care practice geriatric patient care:

> Also, sometimes we are doing harm is a lot of times polypharmacy and can do more harm than we think we're doing good, but you know end up doing harm. So, really figuring out how we can best provide care but also be as minimalist interventions as we can. For me, it would probably be having access to a shared medical record system or share DMR where I can easily get in touch with maybe some of the other specialists for my geriatric patients. Having easy access to maybe a pharmacist, cardiology or neurology and their chart notes because you know being an independent physician, I don't always have that access through the big hospital system. So, it would make things a lot easier.

Overall, the need for comprehensive care inclusive of a pharmacist, would aid PCPs with geriatric patient medication management and potentially minimize polypharmacy. Medication interactions would be minimized with pharmaceutical services intervention and involvement with patient care.

Theme 4: Barriers to Patient Care Due to Limitations of Family Support with Social and Environmental Factors

All participants noted that family involvement was essential to patient care and quality of life for geriatric patients. Although not all patients have family support, any type of outside support is critical for basic needs, medication management, ensuring meeting appointments and care, and for creating a "purpose" for patients.

Family Support as Geriatric Care Component

A22 remarked the need for family, or other, support for complexities as Alzheimer's:

> The bigger piece is when it gets more complicated at with dementia and behavior issues and then still having supports during that time which sometimes are not medical supports or more family supports, and they are not really equipped in place. It would be great if our world could have a support system in our community to help patients when they're struggling.

A27 concurred, noting the importance of family, especially as a care partner:

> It's really, it's just, it is true it's scary on families as well, but I think that if there was one thing that I'm always trying to look for is more resources, whether it's books or podcasts or something that can kind of help people embrace their aging a little more. It's so different for every person whether it's like you live alone and you don't have family, so what's going to happen if you get sick or you're worried that your memory is failing what's going to happen. It's just kind of all

> the unknown and all the variables that are unknown when you age. Yeah, it is all scary.

Also, A28 stressed the importance of family for quality of life:

> So, I know that elderly people don't live forever, and they don't necessarily drop quickly, that they get less and less independent and more dependent on their family or other support stuff and that is very difficult for people to handle the need to get help from other people. So, the idea of geriatrics is that you have a potential to have a really good quality of life if things go your way and you take care of yourself, but it also could be a horrible last couple of years.

A21 added the family component necessary for Alzheimer's and other age-related complexities as well as providing a quality of life and social interaction:

> One, again with a lot of my elderly patient's involvement of family often is a good thing so definitely having that family component. I think it's important you know the social component social interactions I think also important as far as having good outcomes in in the geriatric population and those for me, and other things, that I cannot modify. I think it's relatively easy for me as a physician you know you have diabetes, OK, we know how to manage this you have high blood pressure and we manage this, and some of the other social subtests that is a little bit more challenging. I think for me, I think one of the big factors that's impact that is social factors and what their social network looks like; how involved is a family and taking care of this person helping care for.

A29 remarked the urgent need for family support:

> I'm always running behind and so time is a factor, um family support is a factor. I really think that people that have family support and end up doing better because they have people to lookout for them especially those that are in a nursing home. I thought of a case just the other day where there was this big snafu in medication orders that I sent over for a patient and they did not get the care that they needed. They did not have family involved in this instance and then other times their daughter was there checking up on things and making sure that things happening. It's just a reminder to me of how important family support or friends support is for people.

Family Support for End Stages of Life and Hospice

Participants revealed that family support is an important element for geriatric patients as they transition into hospice and end stages of life. Family support is a vital role in honoring the patients' wishes as well as providing a quality of life at this stage, according to participants. A21 shared thoughts on this subject:

> Keep them as comfortable as possible and so I look at it as a continuum of Care now. Again, I think it's something that inevitable and we can't fight it none of us are getting out of this alive. So, it's being able to do the best we can from patients as they age. I want them as functional as possible trying to alleviate the pain burden of care from medical perspective again. It's family caregivers who get impacted a lot as our patients start to age and no longer able to take care of themselves you know and at the end being able to provide care that will allow them to one day die with dignity. And potentially honor their wishes they wanted

> to stay at home being able to honorable wishes and having them have a comfortable transition.

A22 stressed the importance of families honoring end of life wishes:

> Reaching the end-of-life adults dealt with their parents who didn't really talk about and they're all they have everything set up. They have expectations and plans in place, so yeah, it's very different. A good situation for end of life is when people are like close with their families, they have a lot of family involved. And some people are really at peace with their life and are like "I'm old and I've lived a good life, and this is my time is coming, and I'm going to spend a lot of quality time with my family". And, so I think that that is a more favorable situation.

Participants all concurred the quality of life and easier transitions toward end stages of life as A26:

> And then, the less favorable situation is when people who either don't have the support that they need and therefore are really struggling to take care of themselves, or who are just like not chill with the with the likelihood that that they're going to be dying soon.

Family also provides a sense of the patients' wishes culturally that may be unique and not aligned with the cultural knowledge a practitioner may possess. A27 noted:

> I think it's also hard because culturally sometimes my view of end of life doesn't always align culturally with what some peoples view and so that's just something I've had to me know not to try to impress my views upon people. I do try to be

> realistic about aging and to end of life and some peoples' families don't necessarily agree and so that can be challenging.

Also, A27 added:

> I think that you know geriatrics and the last couple years as I stated earlier there's tons of people who are actively involved in their family or their church or their community and they're having a great old time at 85 and that's good to look for that and encourage people to do that but there's a lot of people who just her alone and isolated and have a miserable last couple years of life.

Lastly, A29 provided insight to family involvement assuaging fears surrounding end stages and providing comfort:

> It's always easier when family is on board it's very difficult if you have different family members who want different things for their loved one. So, I encourage patients to talk about what they want at the end of life with their family before the time comes so that everyone has a written plan.

Overall, all participants agreed that family support was essential for quality of life even at end stages and provided a level of security and consistency with medication management, appointments, and daily care. Family support brought a sense of purpose and the social interaction often minimizing mental health issues like depression.

Theme 5: Joy and Fulfillment Treating Geriatric Patients

The last emergent theme developed was the joy and fulfillment of PCPs had interacting and treating geriatric patients. Aside from the verbal responses, all PCPs spoke compassionately about geriatric care. Attitudes and beliefs determine intentions

which impact behavior (Ajzen, 2002). It was evident that all PCPs interviewed held limited aging biases and all enjoyed their geriatric patient population. As A23 noted "I think it's an important part of primary care practice and I enjoy doing geriatric medicine". A29 shared views on geriatric care:

> I love taking care of my older patients when I first started, I took over and I joined a physician who was getting close to retiring. So, he started saying "medicine that you practice, ages with you" and so because I joined him and he was getting close to retiring, and had been in practice for many years, he already had a lot of elderly patients that I took over. Then I practiced with him for a few years and then he retired, and I took over the business. So, the big, large percent of my practice is geriatrics and it's something I've really grown to enjoy. I just I love talking with my older patients about all their life experiences and the things that they're going through. It's just become a very enjoyable part of my practice. I think of anyone over 65 as geriatric patients.

A27 remarked how geriatric training aided the entire staff with understanding aging complexities and created a positive environment:

> The advantages of geriatric care are all of us are in my practice, the seven of us, are trained in internal medicine and family medicine so we naturally have a lot of experience with geriatrics. Our entire staff is used to caring for that population so I guess that would be the advantage that we're all trained in it.

Also, several of the participants were in longstanding practices, and three PCPs continued a practice upon a retirement, which included a significant geriatric patient base, as A26:

> I would like to say, to be totally honest, that our practice has advantages, as we have a lot of geriatric patients, and our clinic that has been around for a long time. It used to be a private practice and it has been taken over become like an OHSU clinic but a lot of the patients who were with the previous physicians who have now retired or retiring, have stayed on. And are now with the with the newer physicians, those of us who are with OHSU, we've inherited a lot of older patients. Also, because of that our front desk staff, our administrative staff are medical assistants are comfortable working with older adults and we all have a lot of experience with it, so I think that that's a real benefit.

Lastly, A25 highlighted the unique perspective older adults bring and the longevity of relationships:

> I love learning from older generations. I love to absorb their history and their culture and just different perspectives, so I like geriatrics. I see kids, newborns, and I just saw 100-year-old lady with a UTI yesterday, so I like giving them the time of day and making them feel special and making them laugh. I don't think they get that much attention so it's nice for me to be able to provide that.

Each overarching theme captured an element and topic that answered the research question. All participants conveyed attitudes and beliefs toward geriatric care and components that were both favorable allowing each PCP to manage efficiently as well as

limitations of patient care. The experiences shared by each PCP provided significant support to answer the research question.

Summary

The purpose of this generic qualitative study was to answer the research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions. Chapter 4 provided the study's' interview setting, process of data collection and analysis, detailing the semi-structured questions established. The interview questions were presented via phone or online video platform to collect and assimilate participant answers utilizing thematic analysis. Collecting PCPs perceptions toward geriatric care provided insight answering the research question. Utilizing an inductive approach, I analyzed the data coding, then categorizing, and recording emergent themes.

Five themes highlighted the participant attitudes and beliefs toward geriatric care: limitations of geriatric patient care due to Medicare restrictions, the need for a greater comprehensive and integrative approach with mental and social services, understanding polypharmacy, medication interactions and incorporation of pharmacists, barriers to patient care due to limitations of family support with social and environmental factors, and joy and fulfillment treating geriatric patients. The themes culminated from rich and candid responses by participants. The research question: What are PCPs attitudes, beliefs, and actions toward geriatrics impacting treatment decisions, was answered with direct quotes supporting each theme. PCPs attitudes toward geriatric care indicated an overall positivity and compassion toward older adults. Barriers to geriatric care, as Medicare insurance coverage excluding audiology, vision, and pharmaceutical options, were

emphasized by all participants. PCPs revealed the need for geriatric support of polypharmacy and medication interaction knowledge supplementing their treatment planning. Also, participants believed in the importance of family support in the treatment planning process and significance of social and environmental aspects. Candid and open answers explored distinctions of each PCPs geriatric practices revealed significant themes emphasizing elements of care. Although variant themes emerged, all participants noted that quality of life of the utmost importance.

In the next chapter, I interpret the findings, explore limitations of the generic qualitative study and its implications. Analysis of the key findings will show consistency remaining in the conceptual framework. Additionally, I present recommendations for future research as well as implications for social change. Social change is presented with social, environmental, and practical components supporting geriatric care. Lastly, Chapter 5 includes the significance of the generic qualitative study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this generic qualitative study was to explore PCPs attitudes, beliefs, and s toward geriatrics and to expand the understanding of PCPs geriatric treatment decisions (Cunningham et al., 2019; Rhee & Rosenheck, 2019). The goal of this generic qualitative study was to gain a greater understanding of geriatric care within PCP practices in relation to geriatric patient treatments. This generic qualitative study was being conducted to explore mitigating factors of PCP behaviors impacting geriatric care. The data revealed the attitudes and beliefs of PCPs toward geriatric care with key indicators as the limitations of geriatric patient care due to Medicare restrictions, the need for a greater comprehensive and integrative approach with mental and social services, understanding polypharmacy, medication interactions and incorporation of pharmacists, barriers to patient care due to limitations of family support with social and environmental factors, and joy and fulfillment treating geriatric patients.

In this chapter, I present an interpretation and analysis of the data results from Chapter 4, correlating to the literature review. Subsequently, the conceptual framework, limitations, recommendations, and implications are deliberated. Lastly, a summation of the study is presented.

Interpretation of the Findings

Findings Related to the Literature Review

In review of the findings noted in Chapter 4, the five emergent themes revealed were: (a) limitations of geriatric patient care due to Medicare restrictions, (b) need for a

greater comprehensive and integrative approach with mental and social services, (c) understanding polypharmacy, (d) medication interactions and incorporation of pharmacists, (e) barriers to patient care due to limitations of family support with social and environmental factors, and (f) joy and fulfillment treating geriatric patients.

Limitations of Geriatric Patient Care Due to Medicare Restrictions

Participants of the study, PCPs revealed the limitations of geriatric patient care within their practices regarding Medicare restrictions, creating barriers to treatment options. These findings directly support previous researchers who have noted the importance of Medicare that is predominantly focused on medical assessments, diagnosis, and treatment of older adults (Blaum et al., 2018; Mulley, 2012). Regarding Medicare restrictions, Participant A23 noted, "People are really limited on what they can take medicine wise because of Medicare." Bhardwaj et al. (2020) noted the significance of physicians overprescribing to older adults. Participant A26 further corroborated, "If Medicare were better insurance, that would make things easier."

As noted by Schweikart and Eng (2020), PCPs attitudes toward both terminal diagnoses and overall geriatric care determines patient treatment planning, ethical standards, and long-term care. Participant A23 identified the need for changes to Medicare to enhance geriatric treatment options:

> I would say absolutely that Medicare has an impact because nowadays it all depends on what medications are on their plan and what they can afford. It may not be the best medicine, it may not even be the second-best medicine, but we are

> having to use the third or fourth medicine for something because we are limited by their Medicare. And what [the medicines] can cost.

Blaum et al. (2018) noted that patient autonomy is neglected with limited diagnostic pathways. Medicare parameters are not inclusive for basic geriatric needs, such as audiology, vision, or neurocognitive testing. Participant A28 said, "I've seen communication from subspecialists when patients come in, and they're not 100% sure what the subspecialist said they should do and what medicines they should take. Obviously, communication with subspecialists has been a problem in the Medicare system."

Additionally, Participant A22 noted the challenges of Medicare applicability with geriatric practice: "Geriatric patients get offered a Medicare wellness visit, which like I mentioned before sometimes doesn't have as much clinical utility." These limitations of geriatric care due to Medicare insurance are reflected in the literature review as well. As Participant A29 stated:

> For sure, as far as being in a small area, I don't have a lot of other services that people in a larger area would have to offer, as mental health is very difficult to obtain psychiatric care. It is very difficult. It's almost impossible to get anyone into a psychiatrist and a geriatric psychiatrist with Medicare—if I need help that way is almost impossible. So, I've had to learn how to manage a lot of those issues on my own. I don't feel like we have good in-home care. We have home health, but people need more care than that and it's often difficult to find care for

them. So, a larger system … has a lot more resources available to them that I don't have.

Medicare limitations impact geriatric care with prescriptive treatment options, receiving specialized integrative care, and supplemental age-related needs, such as audiology and vision. PCPs provide needed care for geriatric patients and are often limited in the scope of treatments available. The literature review and study findings concur that Medicare is limiting in aiding geriatric care and quality of life with the scope of pharmaceuticals, specialized treatments, and diagnostics.

Greater Comprehensive and Integrative Care

Rhee and Rosenheck (2019) and Masnoon et al. (2017) posited that comprehensive geriatric care beyond prescriptive treatments is needed for minimizing polypharmacy and secondary conditions. Cunningham et al. (2019) suggested further exploration of best practices, age-related issues, and PCP treatment options for comprehensive care. Findings from PCPs confirm the need for comprehensive geriatric care. Participant A23 informed of the need for integrative geriatric care: "I think comprehensive care—you're talking about patient care, outpatient resources, social situations, living situations—become so much more important in evaluating with senior medicine than your typical non-senior medicine."

Also, as noted in the literature review, McCarthy et al. (2017) posited that PCPs adaptability and comprehension with geriatric care are essential with aging population growth and the current AMA model limits on integrative treatment, thus prompting primarily prescriptive options (Petersen et al., 2018). PCPs require a support system for

quality of geriatric care within medical, mental, social, and environmental. Participant A24 concurred:

> I think comprehensive care looks like regular care from whoever oversees primary care, regular care, to evaluate and assess and to make sure that nothing is being overlooked. It would be great if we could have like a whole team of people, pharmacists, to look at medication to address polypharmacy issues. Access to mental health because aging is hard, and it affects different people different ways. I think good access to specialty care and communication with their specialist. So, I guess I'm kind of describing this is medical home.

Geriatric care involves managing complexities, such as Alzheimer's disease. Zhang et al. (2019) noted that geriatric care, specific to Alzheimer's, must consider a total modality approach to care—that is, an integrative approach. Overall, findings supported the need for comprehensive care reducing polypharmacy, providing quality specialized care treatments, and navigating complexities, such as Alzheimer's.

Barriers to Patient Care with Limited Family Support

Geriatrician practices provide comprehensive and integrative assessments that focus on medical, psychological, and environmental needs of older adults (Cantor, 2017). Given that PCPs are the immediate medical providers for geriatric populations, similar components of care are needed as specialized geriatric care (Zhan et al., 2019). Environmental needs include home care, family support and structure of healthcare access to geriatric care especially as comorbidities, complications with neurocognitive disorders, and environmental factors contributing to wellness (Zhang et al., 2019). The

findings support the literature review indicating the relevance and integrative component for PCP geriatric care. Reed and Gibb (2019) described the complexities of aging, including frailty, multiple health conditions, neurocognitive decline, and environmental factors, for many older adults. Participant A26 discussed the family support structure for geriatric care and planning:

> I think I really try and identify what resources patients have and what resources they don't have—or you know the lack of resources that's getting in their way of their treatment. I do my best to work with the resources that people have, knowing that I have a limited ability to get them new resources even though their health outcomes would improve if I could. I don't know. I think I try and identify the resources that they have and try to work within those, and when I can, I try and provide them with additional resources. So, for example, if they're food insecure like getting them set up with [the Supplemental Nutrition Assistance Program]; it's not that hard, but if they don't have any family members or any community contacts, like and they're not religious, and getting somebody a caregiver is a lot harder than getting some of these food benefits. I think like working with the community agencies and other staff as much as we can to fill in the gaps that we can and then also identifying what gaps we maybe can't fill around.

Overall, study findings show that environmental factors, such as family support, are essential. Lester et al. (2020) noted the limitations of PCPs to understand aging and age-related issues, such as physiology, environmental elements, and comorbidities. Study findings show the relevance of family support in providing transportation for medical

appointments, ensuring daily intake of medications, and providing an integral part in geriatric care. As Participant A22 noted, "You just need different resources to help reach those gaps, and typically your family is working, and so having said that, to help you if you don't have family available." PCPs are often more than medical providers, acting as social workers and mental health support when limited or no family support is available.

Geriatric patients without family support often experience increased cases of depression, potential food scarcity, lack of access to health care, and potential injury due to cognitive decline or frailty. Participant A22 noted that Alzheimer's "requires a lot of support for the family and patience." Complexities of Alzheimer's disease and comorbidities require additional support for geriatric patients, and when family support is minimal, quality of life for geriatric patients is impacted negatively.

Understanding Polypharmacy

Study findings supported the literature review noting barrier to geriatric care and limitations of PCPs understanding medication interactions. The need for integrative pharmaceutical support, as with pharmacists, is critical limiting secondary medical symptoms, injury, and early mortality. Rhee and Rosenheck (2019) and Masnoon et al. (2017) posited that comprehensive care beyond prescriptive treatments are needed for minimizing polypharmacy and secondary conditions resulting. Cognitive assessments, meeting geriatric medical, mental, and behavioral health care, and understanding impacts of polypharmacy on aging and age-related conditions, is critical as aging populations increase (Rankin, 2019). Study findings concurred as PCPs noted the critical aspects of polypharmacy and the need for pharmaceutical education or consult by pharmacists.

Participants revealed that psychotropic or psychotic medication often result in negative interactions causing patient harm. All the PCPs interviewed supported the need for reduction in polypharmacy, training of interactions, and Medicare alterations adjusting required and accepted geriatric medications. A29 noted "If you follow all the guidelines and have your patients on all the medicines they are supposed to be on, it's ridiculous." Understanding impacts of polypharmacy on aging and age-related conditions, is critical as aging populations increase (Rankin, 2019). Overall, the findings concurred with the literature review.

Joy and Fulfillment Treating Geriatric Patients

Lastly, all PCPs interviewed revealed the joy and fulfillment they experienced treating geriatric patients. Although the relevance of positive approach to geriatric care was not directly noted in the literature review, the relevance of positive attitudes does determine behavioral outcomes, in this case, with geriatric care. Lincango-Naranjo et al. (2021) noted that attitudes and beliefs toward an action have a greater propensity for beneficence with positive outlooks. Additionally, Lincango-Naranjo et al. (2021) concurred that physicians' attitude and beliefs direct diagnoses, treatments, and patient support. Furthermore, Phoosuwan and Lundberg (2020) posited that understanding physicians' attitudes toward care is critical for changing behaviors toward patient care. Mustafa et al. (2020) substantiated that physician attitudes and beliefs toward aging or age-related diseases as Alzheimer's are biases that must be addressed for best practices and enhanced care.

All study participants showed a positive approach to geriatric care and positivity toward ageing with no aging bias. Compassionate care was revealed by all PCPs interviewed and the fulfillment treating geriatric patients. Overall, training in geriatrics provided a significant basis of knowledge navigating patient care and involvement in finding solutions. Participants were either involved with patients finding social services, housing support, or basic needs, above and beyond medical provider roles. PCPs all noted a compassionate and positive support toward geriatric patients. These findings concurred with the literature review noting the importance of a positive attitude resulting in behaviors enhancing geriatric care.

Interpretation of Findings to Theoretical Framework

Based on the conceptual framework of the Theory of Planned Behavior, findings correlated with the basis of attitudes and beliefs leading to intentions which determine behaviors (Ajzen 1985, 2002, 2011). Lincango-Naranjo et al. (2021) noted that attitudes and beliefs toward an action have a greater propensity for beneficence with positive outlooks. Findings showed the overall joy and fulfillment of all participants treating geriatric patients which promoted behavior involving outside services and support beyond the framework of a medical provider.

In addition to the positive or negative attitudes toward geriatric care, environmental factors were a significant aspect to patient treatment planning. As noted by Ajzen (2002), PCPs behavioral intentions are shaped by positive or negative attitudes, learned beliefs, and behavioral control. PCPs were limited in patient care and scope of pharmaceutical treatments despite positive attitudes, due to Medicare limitations and

parameters, family support, and medical reporting systems. The Theory of Planned Behavior provided an essential framework to developing questions in understanding PCPs attitudes and beliefs toward geriatric care.

Participant findings revealed that despite Medicare limitations with additional services or medication restrictions, all PCPs went beyond medical provider responsibilities supporting patients with phones calls for food services, housing, and support. Findings highlighted the alignment with the framework exploring attitudes and beliefs of PCPs toward geriatric care.

Limitations of the Study

The scope of the study explored the attitudes and beliefs of PCPs toward geriatric care revealing aspects of medical, mental health, social, and environmental that impacted care. Although categories as polypharmacy, Medicare, family support, and barriers to patient care, showed relevance to the research question, limitations of the generic qualitative study were potentially the smaller sample size as representative of a large participant population for generalization. The participants responding to the study were PCPs that were significantly involved in patient care providing additional social services support. All participants were in smaller practices rather than larger health systems or clinics. It is not clearly defined that health systems or larger clinics would provide the equivalent of additional geriatric support or positive attitudes toward geriatric care. Although the study did reveal areas of geriatric care that require attention, the smaller size and even the respondent's involvement with the study may limit the scope to generalize.

Recommendations

Recommendations for future study involving qualitative research would be expanding participant range to health systems and larger clinics rather than the smaller practice size of all participants. Branion-Calles et al. (2019) indicated that not only the sample size but participant bias toward the research presented, could impact response. Although this study's' participants were all from smaller clinics, participant positive bias toward geriatric care may have been present. Further research exploring attitudes and behaviors of PCPs in health systems may reveal other components of geriatric care.

Generic qualitative studies can reach saturation with smaller sample sizes when new participants no longer provide no new themes (Smeets et al., 2019). Although saturation was achieved in this generic qualitative study, all participants were PCPs from smaller practices and further themes may develop with studies exploring attitudes and beliefs of PCPs toward geriatric care within health systems.

Implications

This study provides insight and contribution to a larger body of literature on geriatric care, aging, and social services, as well as medical systems and education. Social change aspects of this study are the developed themes highlighting areas that impact geriatric care for PCPs. Potential social implications are introducing the need for comprehensive approach to geriatric care, development and change needed for Medicare and pharmaceuticals, and advanced geriatric training. This study highlights the need for policy reform and needed support for PCPs. Lastly, the need for Alzheimer's training and

support are evident from the findings indicating the potentiality for educational and policy reform.

Conclusion

This qualitative study contributed to the field of gerontology, geriatrics, and mental health, as well as potentially, all aging professional fields. Exploring PCPs attitudes and beliefs toward geriatric care provided understanding into daily geriatric practices. Relevant areas as polypharmacy, obtaining services and support via Medicare insurance, and the importance of social and environmental aspects for geriatrics, were a few themes impacting patient care. Provider and patient relationships are essential for managing treatments and sustainability of care and this study provided insight. PCPs are the primary providers of geriatric care due to both the aging population growth and limited geriatricians. The need to provide a system and support structure to manage daily geriatric patient care is significant and this study highlighted the need for policy and educational reform to support PCPs.

The Theory of Planned Behavior provided the framework for this study exploring essential motivators of PCPs behaviors toward geriatric care. Attitudes and beliefs, where positive or negative, impact intentions, and thus, behaviors (Ajzen, 2002, 2011). Participants of this study were candid about geriatric care showing barriers, needed support structures, and attitudes toward aging. Theory of Planned Behavior posit those intentions, or motivations, toward a behavior (s) as attitudes, subjective norms, and perceived behavioral control, impact behaviors (Ajzen, 2002; Fleming et al., 2017). PCPs offered valuable insight from their unique experiences regarding geriatric care.

This research filled a gap in literature understanding PCPs attitudes, beliefs, and actions, toward geriatric care in their practices and the impact on treatment decisions (Airagnes et al., 2016; Miller et al., 2017). This study provided nuances of PCP geriatric care, the impact on physician's themselves, and decisions of geriatric treatments (Walsh et al., 2017). The results of this generic qualitative study potentially benefitted PCPs nationwide highlighting gaps in best practices, issues specific to geriatric care, and geriatric training that may provide further exploration (Walsh et al., 2017).

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Appendix A: Recruitment Posting

Seeking Oregon primary care physicians treating geriatric patients for 30-minute zoom or phone interview in next 3 weeks.

If you are a primary care physician treating geriatric patients, I would love to speak with you. Participants must be currently in practice and treating geriatric patients. The interviews will be approximately 20 minutes long on Zoom or phone (your choice). The purpose of this study is to explore primary care physicians' attitudes, beliefs, and actions toward geriatric care. The interviews are a part of a Walden dissertation study for Andrea Holzner, A PhD gerontology student at Walden University. For your privacy, all interviews will be confidential and no identifying information will be shared in reports or presentations. There is no compensation. To confidentially volunteer and schedule a zoom or phone interview please reach out to Andrea Holzner at andrea.holzner@waldenu.edu or 503.866.5529 expressing interest.