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“Are you still driving?” Meta-synthesis of patient preferences for communication with healthcare providers

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Abstract

Aim—To synthesize published qualitative studies to identify older adults’ preferences for communication about driving with healthcare providers.

Background—Healthcare providers play a key role in addressing driving safety and driving retirement with older adults, but conversations about driving can be difficult. Guides exist for family members and providers, but to date less is known about the types of communication and messages older drivers want from their healthcare providers.

Design—Qualitative metasynthesis of studies published on or before October 10, 2014, in databases (PubMed, CINAHL, PsycINFO and Web of Science) and grey literature.

Review Methods—22 published studies representing 518 older adult drivers met the following inclusion criteria: (1) the study was about driving; (2) the study involved older drivers; (3) the study was qualitative (rather than quantitative or mixed methods); and (4) the study contained information on older drivers’ perspectives about communication with healthcare providers.

Results—We identified five major themes regarding older adults’ communication preferences: (1) driving discussions are emotionally charged; (2) context matters; (3) providers are trusted and viewed as authority figures; (4) communication should occur over a period of time rather than suddenly; and (5) older adults desire agency in the decision to stop driving.

Conclusion—Various stakeholders involved in older driver safety should consider older drivers’ perspectives regarding discussions about driving. Healthcare providers can respect and empower older drivers—and support their family members—through tactful communication about driving safety and mobility transitions during the life course.

Keywords

Driving cessation; Transportation safety; Older drivers; Communication; Attitudes and beliefs; Qualitative; Mobility

INTRODUCTION

Driving is a key factor in older adults' well-being and independence, with negative health outcomes resulting from premature "driving retirement" (Edwards et al. 2009; Fonda et al. 2001). At the same time, myriad medications and conditions common with aging can affect driving performance (McGwin et al. 2000), and fatal crash rates per mile travelled rise at age 75 (CDC 2013). The challenge lies in assessing relative benefits and risks for an individual.

Healthcare providers play a key role in identifying potentially at-risk drivers and providing counseling about driving safety and driving retirement in older driver safety (Carr et al. 2010; Wang and Carr 2004). Integrating questioning about driving status in routine clinical care may increase healthcare providers' comfort in bringing up this topic before concerns arise (Betz et al. 2013a). There is evidence that both older drivers and healthcare providers would support such routine questioning (Betz et al. 2014). However, barriers to implementation exist (Betz et al. 2015; Friedland et al. 2006), including inadequate education of providers and the public and inadequate communication between providers and patients (Classen et al. 2007).

Routine questioning about driving in clinical encounters is more likely to succeed if communication strategies focus on proactive planning for future mobility changes. Ideally, providers and older adults would also engage periodically in productive conversations about driving safety in general. This requires a contextual understanding of older adults' perceptions and preferences for messaging about driving. Traditionally the study of in-context understandings requires primary qualitative study, which can be time-intensive, typically involves a small sample, and may have limited transferability of findings. Synthesizing existing primary qualitative studies offers an opportunity to examine the variety of ways and settings in which messaging occurs across a diverse group of older adults. Building from existing interpretations also substantially enhances the breadth of transferability of findings (Tong et al. 2007; Sandelowski and Barroso 2007).

We therefore synthesized qualitative studies of older adults' preferences for communication with healthcare providers about driving, driving safety, and planning for "driving retirement," accessing a diverse range of perspectives and driving contexts. These results should inform the future development and refinement of messaging to older drivers, which in turn could support the integration of communication about driving into routine clinical care or community-based programs.

METHODS

Study Design

Consistent with established guidelines (Tong et al. 2007) we designed a qualitative metasynthesis grounded in social constructivist epistemology consisting of: identification of a research question; definition of the scope and nature of studies to include; team-based quality appraisal of each relevant identified study as a preliminary step in data analysis at the macro level; team-based, inductive theme analysis at the micro text data level; and

development of an authenticity map by producing a reciprocal translation table (Goins et al. 2014). As a rigorous systematic interpretive study of a body of qualitative research literature (Bondas and Hall 2007; Sandelowski and Barroso 2007), the aim was the production of new knowledge beyond the original studies. The process involved interpretations of interpretations (McCormick et al. 2003) and an interpretive, integrative synthesis (Thorne et al. 2004). We also followed these assumptions: the whole published paper, not just participant quotes, is treated as qualitative data for interpretation; a multidisciplinary analytic team adds context variation to interpretation of studies; when qualitative studies are about similar things, they can be “added together.”

Inclusion and exclusion criteria—We included studies that: were published; included drivers (or former drivers) aged ≥ 65 years; mentioned communication with healthcare providers about driving; used qualitative methods; and were indexed in a bibliographic database by October 2014. We excluded studies that: were not written in English; combined qualitative and quantitative data; or did not include primary data collection (i.e., were systematic reviews, meta-syntheses, editorials, or literature reviews). Although the focus was the perspectives of older drivers, studies remained eligible if they included other types of participants (e.g., family members or drivers aged <65 years) in addition to older drivers. However, in studies of heterogeneous populations, we included only content explicitly attributed to an older participant.

Search Strategy

With a health sciences librarian, we searched PubMed using the National Library of Medicine’s Medical Subject Headings and additional key words related to: (1) older adults (“Geriatrics”, “Aged”, “Elderly”, “Older adult”); (2) driving (“Automobile driving”, “driving”); and (3) qualitative research (“Qualitative Research”, “qualitative”, “focus group”, “interview”). We supplemented this search with similar subject heading and key word searches in CINAHL, PsychINFO, Web of Science, and Google Scholar. We also conducted general internet searches to identify relevant grey literature, including reports from studies done by organizations involved in policy development or education in the area of older driver safety (e.g., AAA Foundation for Traffic Safety, AARP, Massachusetts Institute of Technology Agelab, and National Transportation Research Board). Reference lists of included studies also hand-searched for additional relevant studies.

Study Selection and Appraisal

Article adjudication—Two reviewers (MEB and KS) independently performed the above searches and examined each title for relevance to our study question: older adults’ preferences for communication with healthcare providers about driving. The two reviewers examined the abstracts of titles deemed potentially relevant by either reviewer; subsequently, they reviewed the full text of these latter studies. Both reviewers agreed upon the final set of articles. Final inclusion in our study was confirmed during our whole analytic team discussions following methodological critical review.

Methodological critical review—For critical review of each study, we chose the McMaster University tool (Letts et al. 2007) because of its comprehensive criteria for study rigor and other methodological points

Interpretive Analysis

We used a general inductive approach (Thomas 2006) to qualitative theme analysis of similarities and differences across the published studies. We applied our team-based, inductive and deductive analytic toolkit, including line-by-line reading and definition of emergent ideas, codes and then themes (Betz et al. 2014; Jones et al. 2014). The process was iterative, building consensus through visual mapping of themes, naming, re-naming and contextualizing themes through team discussion. This approach extends analysis to going beyond the original studies to more abstract level theme development. Congruent with our metasynthesis framework (Thorne, et al. 2004), we then used a reciprocal translation approach adapted from Noblit and Hare (Noblit and Hare 1988). We used a parts-and-whole movement as a team within and across each study, each team member, and at each team analysis discussion. We maintained an analytic audit trail of our decisions.

RESULTS

Search Results

Our initial search yielded 499 studies (Figure 1). Both reviewers examined the full article for all abstracts deemed relevant by at least one reviewer (n=103 studies). The final 22 studies included in this metasynthesis were chosen by consensus after full article review: Adler 2010 (#1); Barnsley et al. 2012 (#2); Bauer et al. 2003 (#3); Betz et al. 2013a (#4); Betz et al. 2014 (#5); Byszewski & Molnar 2010 (#6); Friedland & Rudland 2009 (#7); Jett et al. 2005 (#8); Johansson & Stromberg 2010 (#9); Johnson 2000 (#10); Johnson 2002 (#11); Johnson et al. 2013 (#12); Liddle 2013 (#13); Moore & Miller 2005 (#14); Perkinson et al. 2005 (#15); Persson 1993 (#16); Rudman et al. 2006 (#17); Tuokko & McGee 2002 (#18); Vrkljan et al. 2010 (#19); White et al. 2012 (#20); Whitehead et al. 2006 (#21); Yassuda et al. 2006 (#22).

Study and Participant Characteristics

Table A1 (online) displays the full characteristics of the included studies. The studies were conducted in: the United States (#s 1, 3, 4, 5, 8, 10, 11, 14–16, 22); Australia (#s 2, 12, 13, 20, 21); Canada (#s 6, 7, 17–19); and Sweden (#9). Only one study (#16) was published before 2000. Most studies used a qualitative descriptive approach with interviews, focus groups, or a combination. Eight studies (#s 11, 12, 14, 16, 17, 20–22) included only older adults, while the others included a range of stakeholders. The sample sizes ranged from four to 216. The combined qualitative data from these 22 studies represents a total of 518 individual older adults.

Methodological Critical Review

All studies had a defined purpose and review of relevant literature, and all identified a descriptive or exploratory scope to their qualitative approach (Table A2, online). Four studies further defined their approach as phenomenological and one as empirical grounded

theory. Consistent with contemporary debates (Jones 2013), in naming of the stated type of qualitative approach and the associated method, slippage was evident in the majority of manuscripts examined. While all studies appeared to include participant samples appropriate for the research question, two did not provide information about how participants were recruited, and only eight stated whether sampling was continued until the point of data saturation. All studies had analytic rigor, including inductive analyses and findings that appeared consistent with and reflective of data. However, no study described an auditable decision trail, and five did not describe data analysis techniques in detail. In all but two studies, a meaningful picture emerged of the phenomenon in question. Regarding overall study rigor, concerns about transferability were most common, followed by confirmability; only two studies had issues related to either credibility or dependability. This process of critical review was used as a first step in the analytic process, and no study was excluded based on critical review findings (Sandelowski and Barroso 2007).

Metasynthesis

Five analytic themes emerged from our metasynthesis (Table 1). We found that communication about driving is an (1) emotionally charged and (2) context-sensitive topic for older drivers that best occurs (3) with trusted providers (4) over time and (5) in a way that allows the older adult to maintain agency. We linked the primary studies to these themes through reciprocal translation as described in Table 1 and in the narrative below, with illustrative quotes from participating older drivers.

Theme 1—Driving discussions are emotionally charged—Driving is a sensitive topic for most older adults. Older adults named a range of negative emotions when describing driving cessation, including sadness, powerlessness, frustration, anger, and decreased self-esteem. Communication about driving can stir fears of the loss of driving privileges: “Nope, I’d never talk about it with [my nurse practitioner]. Too scared that I’d have to stop driving and then where would I be?” (#10). Feelings of denial, disbelief, victimization and persecution were also common when older adults disagreed with providers’ assessments or recommendations. One woman reported feeling justified in ignoring her provider’s advice: “My doctor is badly mistaken about my driving skills. There is absolutely nothing wrong with them; I’m just a bit slower than before, but that’s no reason to quit” (#11). Some older drivers also expressed anxiety over harming others and indicated that providers’ comments about community safety could influence their decisions about driving. Older drivers generally wanted providers to acknowledge how difficult the topic can be, and to offer emotional support. Drivers also spoke of a need for hope, like assurances that their transportation needs would be met. Conversations focusing on the positive aspects of driving evaluations, such as adaptive equipment or future re-testing, and conversations that occur routinely might make the discussions less emotionally charged.

Theme 2—Context matters—The interaction between the driver, provider, clinic environment, social context and point in time can affect both the tone and outcome of the conversation. Participants recognized that time constraints in clinical settings may inhibit conversations about driving, but older adults spoke of a desire to be recognized as an individual, rather than feeling like a “name on a list” (#20). One participant summarized her

advice for providers: “‘Let me get to know you....are you still driving? Do you have any issues with that?’ That kind of question, rather than ‘an old person like yourself shouldn’t be driving.’ As in most things, it’s in how you present the question” (#5). The older driver’s gender can affect both self-perceived driving ability and self-identity related to driving. Participants also suggested that if a provider is concerned that a specific medical condition or medication poses safety risk, reference to the condition may make older adults more comfortable with the conversation. This might also lead to disease-specific recommendations and resources. Disease-specific recommendations and resources may be particularly useful for emotionally-charged diagnoses or conditions that impact communication itself, such as dementia or stroke. In the absence of clear guidelines, though, conversations are left to the provider’s discretion. Some providers may be more likely to initiate a conversation than others and a particular diagnosis or risky medication alone does not ensure a conversation about driving will occur. Furthermore, geographic location affects cultural values, as well as the availability of alternative transportation and resources that support prolonged driving. The relative emphasis a community places on the well-being of the community versus individual rights, which may vary by rurality, region or country, may also affect how providers discuss driving safety with older patients. For example, one Australian woman said: “The doctor didn’t approach me to give it up. I approached him. I said to him that I was thinking about it and he said: ‘It wouldn’t hurt. You have to think of other people’ ... I would hate to have an accident and hurt anyone, let alone children” (#12). Regulations that require providers to report potentially unsafe drivers vary geographically, as well. Regulations might inhibit conversations out of fear of license revocation but they might also help drivers understand and accept providers’ recommendations. One former driver commented: “It’s really counter-intuitive to expect older people to, well any age, to have the objectivity to decide”. (#17)

Theme 3—Healthcare providers as trusted and influential—Older adults viewed healthcare providers as authority figures and many said they would follow medical recommendations even if they disagreed or felt the decision was forced upon them: “My doctor told me I had to [stop driving]. I just had to do what he said” (#3). Drivers also spoke of providers as a back-up to their own autonomous decision-making process (see Theme 5): “I’m sure I’ll know enough to quit driving when I should, but I’m not certain that I will. I hope that I will, but I’ll be told when I mustn’t” (#7). Driving discussions are best conducted by a well-known, trusted provider. Participants preferred to have counseling from their provider rather than medical assistants. Providers were generally described as fair, knowledgeable and influential; one driver said, “I’d listen to my doctor first” (#1). In another study, a participant elaborated: “Well, [my nurse practitioner] takes good care of me every other way, so why wouldn’t I trust her to lead me down the right path when it come to the stuff I needed to drive good?” (#10). Importantly, some participants took the absence of guidance from providers as implicit approval to continue driving (#14). Whether driving is an appropriate topic for conversation in a clinical setting may vary by patient. Many older drivers saw driving as related to other health conditions and therefore relevant to medical providers and an acceptable topic of discussion: “[My providers] ask me everything else” (#4). However, there were also strong statements from some who saw driving as a personal issue: “My driving is my business and no one else’s” (#10). A participant in another study

said: “I still got [my license] in my pocket, because the man who was giving me his biased opinion, he was a doctor thank you very much but he wasn’t in the position to take away my license” (#6).

Theme 4—Continued communication over time—Communication that occurs over time allows older drivers to process recommendations, make plans, and adapt their lifestyles. Older adults spoke of the need for support and time to reflect on the process of adjusting driving to physical challenges, medication effects and eventually, driving retirement. This may even take the form of “grief counseling” (#13), given the potential emotional consequences of driving retirement. Older drivers supported the idea of advance planning, with conversations beginning sooner to avoid the need for abrupt and unexpected changes. One study included an appendix of recommendations for healthcare professionals caring for older drivers with dementia; first on the list was preparing patients for future driving retirement: “...they hit you with that, bang, you should be warned” (#6).

Theme 5—Desire for agency—Older drivers wanted to maintain control over their decisions, albeit with input from trusted individuals and reliable information sources. This was a strong emergent theme, with evidence in all included studies. Some participants spoke of choosing to stop driving voluntarily (#3): “I am in control of this body, and I decide what this body can do and can’t do” (#16). Participants also wanted objective evidence, such as test results or a specialist’s opinion, to help them make decisions: “If somebody said to me that they were concerned with the way I drove, I would want to know what concerns you. And take a look at what they’re saying” (#5). A strong subtheme was that participants felt they had received inadequate and inconsistent information about driving safety and the process of testing and cessation. This lack of information was identified as a source of stress. One man said that, when he was discharged after being hospitalized with a stroke, “I was never told you couldn’t...that you couldn’t drive straight away...” (#19). The studies suggested that better education can empower older drivers to seek assistance or retraining, to self-restrict their driving, or to transition to other modes of transportation. The best approach may be a collaborative one in which the provider engages and empowers the older driver to make informed, rather than forced, decisions.

DISCUSSION

Our findings support the role of healthcare providers in talking with older adults about driving. While guides for healthcare providers and family members exist, the evidence basis for their communication recommendations was unclear. This qualitative metasynthesis supports suggestions advocating an empathetic and engaging approach to the emotionally-charged topic of driving. Our findings also suggest providers strive to make conversations both routine but also context-specific and individualized. Integrating questioning about driving into regular primary care visits, for example through the annual Medicare Wellness Exam (Betz et al. 2013a), might allow older adults time to process, prepare and adapt. An important gap to address is the need for improved education of patients, providers, and the general public.

One emergent theme—the view of healthcare providers as trusted authority figures—is consistent with prior calls for healthcare providers’ involvement in assessing and counseling older drivers (Carr et al. 2010). However, our findings suggest discussions about driving may occur only sporadically and provider guidance may be inconsistent. Another theme from this metasynthesis—older drivers want conversations to occur over time—adds weight to the argument that driving should be discussed long before there are specific concerns. Such anticipatory conversations might empower older adults to seek out information or retraining and to make their own decisions. Such conversations might also lay the groundwork for future conversations about driving retirement (The Hartford 2010).

Although routine questioning might “normalize” the topic, our findings also emphasize the need for personalized counseling. Older drivers vary in their openness to discussing driving and in their preferences for when and with whom to have such conversations. However, the fact that a subset of older drivers will not want to talk about driving should not be a reason for healthcare providers to avoid the topic with all older patients. Rather, providers should contextualize the topic by relating it to an objective concern or potential risk, such as a medical diagnosis or medication (NHTSA 2006), and should discuss the risks and benefits of driving with each individual patient. Tools to help individualize the conversation include decision aids (Carmody et al. 2014), “advance driving directives” (Betz et al. 2013b), and the Assessment of Readiness for Mobility Transition (Berg-Weger et al. 2013). These approaches help providers adapt their style of feedback and conversation with older adults to better support older drivers’ progress through the stages of change related to driving retirement (Hassan et al. 2015). Providers should support and encourage older adults in making their own decisions about driving as long as they are able, as maintaining this control can enhance satisfaction and decrease a sense of victimization after driving retirement.

An area for further research is positive reframing in discussions about driving. While providers should acknowledge the emotionality of the topic and the connection between driving and independence, overemphasis of this link could perpetuate the idea that driving retirement leads to inevitable depression, social isolation and death. Positive reframing can occur within a conversation with an individual, for example through emphasizing the financial savings and decreased anxiety over crashes that may come with driving retirement. At the level of the public, positive reframing could take the form of educational campaigns featuring older adults who have retired from driving but remain socially-engaged and happy. While these ideas were suggested in some of the synthesized studies and have been mentioned previously (NHTSA 2006; The Hartford 2010), there is inadequate empirical qualitative or quantitative evidence about how such campaigns could be successfully developed or disseminated.

The finding that older drivers received inadequate or inconsistent recommendations from their healthcare providers suggests an education gap. The American Medical Association (AMA) and National Highway Traffic Safety Administration (NHTSA) developed the “Physician’s Guide to Assessing and Counseling Older Drivers” (Carr et al. 2010) and a related web-based curriculum for healthcare providers. Initial results suggested training effectiveness (Irmiter and Schwartzberg 2011; Meuser et al. 2014). The curriculum is no

longer available online (2014), but the guide is on the NHTSA website (Wang 2003). However, a new initiative by NHTSA and the American Geriatrics Society aims to educate healthcare providers about older driver safety (Hurd 2014). These efforts will likely include the AMA online curriculum and other materials.

Limitations include that we may have missed materials that were unpublished, were in languages other than English, used mixed methods, or were published after October 2014. However, a medical librarian assisted in search multiple databases and grey literature. Study heterogeneity in sampling, scope, and quality may have affected our results. Some studies also included younger drivers (in addition to older drivers), but none of these contributed outlying themes or subthemes. Future work examining the views of older drivers of subpopulations (e.g., varying races and ethnicities), and of younger drivers with medical issues affecting driving, would be useful to optimize targeted messaging.

CONCLUSION

This metasynthesis, incorporating 22 studies from four countries with over 500 older adult participants, brings new understanding to older drivers' preferences for communication with healthcare providers. Our findings could inform efforts to support respectful and effective conversations about driving between older drivers and their providers; these efforts could include provider education, embedding of appropriate questions within the electronic medical record (Betz et al. 2015), and other system changes. While conversations about driving can be emotionally charged for all parties involved, healthcare providers are uniquely positioned to establish trusting, tactful conversations with their older adult patients regarding the risks and benefits of driving and future transitions to other forms of transportation.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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MEB participated in study concept and design, literature search and study review, theme analysis, and manuscript preparation, and she takes responsibility for the manuscript as a whole. KS participated in literature search and study review, theme analysis, and manuscript preparation. JJ participated in study concept and design, theme analysis, and manuscript preparation. CD participated in study concept, theme analysis, and manuscript preparation.

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Figure 1.
Article Selection Process

Table 1

Team Synthesis and Reciprocal Translation

Derived analytic theme & subthemes	In paper # (per text and table A1)	Themes from primary studies
1. Emotionally charged: This theme reflects the idea that discussions about driving are sensitive and can trigger strong emotions		
Fear of emotionality and consequences of conversation	2, 5, 7, 10, 11, 13, 14, 17, 19	Older drivers and providers reluctant to bring up topic of driving because of potential consequences, including harm to provider-patient relationship; some drivers fear license loss if they ask for help
Driving cessation is painful	2, 6, 9, 13, 17, 20, 21	Emotions triggered by driving discussions (especially by driving cessation) include sadness, powerlessness, frustration, decreased self-esteem, anger and anxiety.
Denial and disbelief	6, 11, 14, 15, 16, 21	May react with disagreement, denial and disbelief; after license revocation, some may feel victimized or persecuted
Anxiety over community safety	5, 6, 8, 12, 17	Fear of harming others may be stronger than fear of harming self
Acknowledgment that topic is emotional	6, 8, 13, 14, 17, 21	Want providers to recognize that driving discussions and safety trigger many emotions, also want emotional support.
Need for hope	3, 5, 14, 15, 17, 19, 21	Reframe discussion to focus on positive aspects (evaluations, car adaptations, disability permits, off-road driving, re-testing in future, decreased anxiety after cessation)
Normalization of discussion may reduce emotionality	4, 5, 7	Less emotionally charged if make questions/ discussion routine
2. Context: This theme refers to the context of conversations about driving (individual driver, environment, and point in time)		
Context affects emotionality & agency	5, 6, 17	The interaction between driver, provider, environment and time can affect conversations and support for driving conversations and evaluations; Recommendations for constructive conversations (routine, anticipatory guidance)
Want to be recognized as individual	2, 4, 5, 8, 13, 16, 17, 19, 21	Standardized approaches can be useful but must be personalized to acknowledge variability in driver opinions, ability, and reactions to conversations
Gender	3, 12, 20	Gender can affect perceptions of driving and relation to self-identity
Medical diagnoses	6, 13, 14, 15, 16, 17, 18, 19, 20	Prefer conversation prompted by diagnosis (or "red flag") rather than age alone; for some conditions (e.g., dementia), need to acknowledge emotional impact of diagnosis itself; useful to provide resources specific to condition
Medications	13, 16, 20, 22	Medication effects or changes can prompt conversation though often don't
Geographic location	11, 12, 17	Values may differ by locale (urban versus rural) and country (Australia, US, Canada)
Regulations	6, 10, 13, 17, 18, 19	Legal reporting requirements can inhibit conversations but may also help drivers understand or accept recommendations to retire from driving
3. Trusted, influential provider: This theme speaks to the idea that older adults are open to discussions with a trusted healthcare provider		
Provider as trusted authority figure	1, 2, 3, 4, 5, 6, 8, 9, 10, 12, 15, 16, 17, 20, 22	Providers generally identified as fair, knowledgeable and influential concerning driving; discussions are best when there is an established relationship; provider recommendations often followed even if older adult disagreed

Derived analytic theme & subthemes	In paper # (per text and table A1)	Themes from primary studies
Provider as safety net	7, 12, 14, 16, 17, 18, 22	Want a “back-up” in case they don’t recognize own limitations; absence of guidance may be taken as implicit approval to keep driving
Provider’s role vis-à-vis clinic staff	5, 10	Time constraints may limit conversations, but prefer to have counseling by physician (not nurse or medical assistant)
Provider’s role vis-à-vis family	1, 3, 6, 16	Provider’s input may be more influential or palatable; collaboration or back-up by family helpful; family welcomes/prefers physicians to introduce topic
Driving as health issue	5, 7, 15, 19	Driving is related to other health conditions; framing driving as a health issue facilitates conversations
Driving as personal issue	4, 6, 9, 10, 16, 17	Some older adults not open to discussions with or recommendations from providers
Providers don’t know their driving ability	4, 5, 6, 7, 17	Providers don’t always know patient’s abilities; patients may disagree with provider’s assessment of their fitness to drive
Providers need education on driving as a health issue	2, 3, 6, 17	Providers need information, resources to be able to advise and assist their patients
4. Communication over time: process, plan and adapt This theme reflects the need for communication about driving to occur over time to allow drivers to		
Facilitated reflection	3, 6, 7, 8, 9, 11, 13, 15, 20, 21	Want support and time to reflect
Want advance planning	3, 4, 5, 6, 7, 13, 14, 15, 20, 21	Conversations need to begin earlier to help prepare for future transitions
5. Desire for agency: This theme concerns older adults’ desire to maintain control over their decisions and their driving, albeit with input.		
Want to make decisions	2, 3, 7, 8, 12, 13, 16, 17, 21	Controlling decisions about driving may enhance satisfaction and decrease sense of victimization; some may decline testing and proactively choose to stop driving; may be especially important for those with early progressive dementia
Want objective evidence	4, 5, 6, 9, 11, 12, 13, 16, 17	Objective evidence helps older drivers feel comfortable with decisions; this can include testing or referral to specialists for a second opinion (9: “had not received any acceptable explanation to why they were not permitted to drive”)
Testing and retraining	5, 15, 16, 17, 20	Testing seen as helpful but potentially frustrating process
Need for education (often inadequate or inconsistent)	1, 5, 9, 12, 13, 14, 15, 16, 18, 19, 20, 22	Process of driving cessation would be easier with better education and support; education may lead drivers to seek assistance, self-restrict, retrain, or switch to other modes; lack of information or clear advice is a source of stress
Empowerment	7, 13, 18, 20	Discussions with providers can empower older adults to monitor themselves and make informed decisions
Collaborative approach	3, 8, 9, 13, 15, 22	Collaborative approach engages older driver and avoids forced decisions; can involve peer discussions or “driving contracts”