



Who Drives Older Driver Decisions?

Joseph F. Coughlin¹
Maureen Mohyde²
Lisa A. D'Ambrosio¹
Jennifer Gilbert¹

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¹AgeLab, MIT, 77 Massachusetts Avenue, E40-279, Cambridge, MA 02139

²The Hartford Financial Services Group, Inc., 200 Executive Blvd., Southington, CT 06489

MIT AgeLab

The MIT AgeLab develops new ideas and technologies to improve the quality of life of older adults and those that care for them. Based within the MIT Engineering Systems Division and Center for Transportation & Logistics, the AgeLab has assembled a global, multi-disciplinary team of researchers and business partners to design and develop practical innovations that support independent living, health & wellness, lifelong productivity and caregiving.

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Dr. Joseph Coughlin of MIT and the Corporate Gerontology Group at The Hartford are committed to producing original research that can expand the understanding of older drivers and their families as they deal with changes in driving abilities.

Through professional meetings and public education, The Hartford/MIT AgeLab partnership has successfully reached millions of people in the United States and across the globe with high-quality, meaningful information to guide important decisions about safe driving.

Study Authors

Joseph F. Coughlin, Ph.D. is Director of the MIT AgeLab and leads the US Department of Transportation's New England University Transportation Center. He teaches transportation policy in the MIT Engineering Systems Division. He is co-author of a forthcoming book on older driver re-licensing and national transportation policy.

Maureen Mohyde, MA, ChFC is Director of Corporate Gerontology at The Hartford Financial Services Group and is Co-Director of The Hartford/MIT AgeLab Safe Driving for a Lifetime Research Program. She is a Visiting Researcher at the MIT AgeLab.

Lisa A. D'Ambrosio is a Research Associate at the MIT AgeLab. Prior to joining the AgeLab, she was a Research Analyst with the US Department of Transportation's Volpe National Transportation Systems Center, USDOT. Her doctoral work at the University of Michigan is in public opinion and survey research.

Jennifer Gilbert is a Research Assistant at the MIT AgeLab and is pursuing her doctorate in psychology.

Please address all correspondence to: Joseph Coughlin, Ph.D., (617) 253-0753, e-mail: coughlin@mit.edu

Abstract

Decisions around limiting or stopping driving are among the most difficult that older adults may have to face. There is a paucity of research related to decision making with respect to older drivers, family members and other “trusted” individuals, such as adult children and physicians. We consider preferences older drivers have for conversations with others who have concerns about their driving, giving particular attention to the role of family members, and when such conversations are appropriate. We draw on focus groups and a large national survey of older adult drivers in the United States to explore questions around the role others play in older adults’ decisions around driving, and when such involvement is more likely to be welcome. Overall, participants reported engaging in some degree of voluntary self-regulation of their driving in order to continue to drive safely. People generally preferred to be approached by individual family members as opposed to those outside the family (such as a close friend or the police) when having conversations about their driving. Differences emerged in preferences for who should speak with the older driver based on household status. Most older adults who are married preferred to hear first from a spouse, although the choice was not universal; over 18% of those who were married with a spouse in the household reported that they absolutely did not want to hear from their spouse about driving concerns. Doctors and adult children were also preferred choices for conversations. In cases where older adults lived alone, doctors, followed by adult children, were most often selected. In general, people expressed consistent rankings for why they trusted others to speak with them, and for reasons people should initiate a conversation about their driving. We conclude with a discussion of some of the implications of the research for having conversations with older adults about concerns with their driving.

Introduction

We live in an aging society. Adults 65+ are the fastest growing segment of the population and the very old (85+) are the fastest growing sub-component. These added years – “the longevity bonus” – present both vast opportunities and challenges. Automobile accidents that involve older drivers call attention to important issues associated with older adults, decision making and driver safety. These issues are driven by both current and recurrent events. For example, in July 2003, in Santa Monica, California, an 86 year-old man made a wrong turn into a crowded farmers market. What made this incident particularly horrific was that the driver, after making the incorrect turn and hitting people, continued to drive for nearly three blocks, leaving carnage in his wake. Ultimately more than fifty people were injured and approximately ten were dead. This accident in particular was described by the media in gruesome detail: “Bodies were flying...there was a dead man on top of the car and a woman under the car” (Mohan 2003; Schodolski 2003). In one of many statements, the driver explained that he inadvertently stepped on the gas pedal instead of the brake. While this event was sensational and widely reported, it is not representative of the overall experience of older drivers.

When such a tragedy occurs, media reports are frequently misleading and typically overestimate the number of accidents attributable to older drivers. In actuality, statistics indicate that most older adults are safe drivers, with high safety belt use and few citations for speeding, reckless driving or alcohol-related charges. In fact, the number of accidents involving older drivers and chronological age are inversely correlated, with total accidents decreasing as one ages. In fact, older drivers are among the safest drivers on the road. They represent 14% of licensed drivers, but are involved in only 8% of police reported crashes (Straight and McLarty Jackson 1999). Furthermore, older adults are quite proficient in making informed choices to

continue to drive safely as they age by self-regulating their driving behavior (e.g., only driving during the day or not driving in inclement weather). Many older adults (ages 75+) are, however, at a higher risk than their younger counterparts for sustaining serious injuries and fatalities when involved in a motor vehicle accident. This is partly attributable to fragility, a lower threshold to withstand physical trauma (Insurance Institute for Highway Safety 2001; Li, Braver and Chen 2003). It should be noted, however, that the age at which these physiological changes occur varies from one individual to the next.

Today's older adults and tomorrow's – the Baby Boomers – have higher incomes, more education and improved health – all of which suggest that tomorrow's older adults are more likely to pursue a range of activities requiring transportation that is responsive to this active, albeit older, lifestyle (Cobb and Coughlin 1999). Despite this knowledge, modest progress has been made in terms of implementing new legislation and policy changes to enhance the future of transportation to meet the needs of an aging society better. One of the major impediments is the lack of alternate transportation options to driving. Public transportation as currently designed will be unable to fulfill the demand for transportation among older adults. In addition to the trends that improved the status and health of older adults, throughout the past half century in the United States there has also been a growing trend toward suburbanization, placing more people farther away from transportation alternatives than in previous generations. For many, taking public transportation is simply not an option because it does not exist. Public transit also has inherent characteristics that make it less attractive to older adults, including the frequency and reliability of travel, monetary cost, personal feelings of safety and comfort, and its accessibility for people who have physical challenges as they age (Suen 1999). Public transportation use among older adults (65+) is estimated to be between only 1.5 and 2.3% of their total trips

(Rosenbloom 2004). The ideal transportation choice among older adults, next to driving, is to ride in a car with one's friends and family.

Yet we know little about how older drivers make, or prefer to make, decisions around driving. There is a paucity of research related to decision making with respect to older drivers, family members and other "trusted" individuals (e.g., adult children, physicians, close friends, etc.). To that end, we consider the preferences among older drivers for conversations with others who have concerns about their driving. Specifically, we explore whom people prefer to talk with about their driving, giving particular attention to the role of family members, and when such conversations are appropriate. In essence, we attempt to provide a preliminary outline of the parameters of who and what should be involved in the decisions around driving that older adults make.

Older Adults and Making Decisions around Driving: Previous Research

Transportation has been described as the "glue" that holds all our daily activities together. Ready access to family, friends, social activities, health care, goods and services, and other social outlets are vital to one's full participation in daily life (Carp 1988). For most, the automobile is the key to individual mobility, and the driver's license is a symbol of autonomy and competence. Marottoli et al. (1997) found that having stopped driving was one of the strongest predictors of increased depression symptoms among older adults, even after controlling for demographic and health variables.

Driving, however, becomes a somewhat more difficult and challenging task in conjunction with the physical and cognitive changes associated with aging. The literature suggests that older drivers often make wise decisions in modifying driving behavior to

compensate for such physiological and cognitive changes. Examples of self-imposed modifications include decisions to avoid driving in the evening, in inclement weather, or in other demanding situations (such as heavy traffic), as well as reducing the number of miles traveled. This self-regulation of driving is widely noted as the means by which older drivers make adjustments to their driving to continue to drive safely (Ball and Owsley 1991; Hakamies-Blomqvist and Wahlstrom 1998; Jette and Branch 1992; Marottoli et al. 1998; Richardson and Marottoli 2003; Siren, Hakamies-Blomqvist and Lindeman 2004).

Eisenhandler (1990) calls the driver's license the "asphalt identikit." Driving, however, does not necessarily remain an option throughout life (Jette and Branch 1992). Since the ability to drive is connected in so many respects to an individual's life and to positive feelings of independence and self-worth, the decision to stop or limit one's driving is often a very stressful and difficult one. Thus, while the individual has most often been identified as the primary decision maker around choices regarding driving, we know little about the role and influence of other trusted people (e.g., family and friends) in making or supporting this decision.

There is research in other contexts to indicate that other variables may influence the important choices that older adults make.¹ For example, previous research on the utilization of long-term care by older adults emphasizes the importance of psychosocial factors, especially norms regarding family caregiving as well as perceived expectations and burden, in influencing healthcare choices among older adults (Bradley et al. 2002). The role of the family in contributing to healthcare decisions is not restricted to influencing the specific family member that may require medical care, but may also extend to the treating practitioner as well. For example, Al-Doghether and Al-Megbil (2004) surveyed one hundred primary care physicians

¹ There is a long and rich history of research on decision making in social psychology (e.g., Hovland, Janis and Kelley 1953; Slovic 2000; Tversky and Kahneman 1973).

about their knowledge, attitudes and practices on prescribing medication for older people. Over one fourth of the sample of doctors reported that family members influenced their prescribing decision. Indeed, understanding not only the patient's experience and expectations, but also those of family members, is an important factor for physicians to consider to improve patient understanding, involvement and improved decision making (Epstein, Alper and Quill 2004). We suspect that some of these same family dynamics should also be involved in older adults' decisions around driving.

Methods

We draw on a number of focus groups and a large national survey of older adult drivers in the United States to explore questions around the role others play in older adults' decisions around driving. Focus groups are powerful means to understand "why people think or feel the way they do" (Krueger 1994, 3). They provide nuanced, contextual information that could not be easily obtained from a survey (Morgan 1998).

Thirteen focus groups were conducted across five different sites in 2001.² Twelve of the groups were done with older adults; participants in these groups ranged in age from 58-89 and were either current or former drivers. Forty-four participants were men and 59 were women. The groups were designed to facilitate comparisons by gender and by typical driving environment (urban or suburban). The thirteenth group was designed to assess physicians' views of older drivers. Eight general practitioners (five male, three female) who routinely treated individuals over the age of 70 participated in this group discussion. Although the foci of these groups varied slightly, all groups primarily examined issues revolving around older driver

² The focus groups were conducted in Boston and Framingham, Massachusetts, in Chicago and Deerfield, Illinois, and in Clearwater and St. Petersburg, Florida.

decision-making, the role family play in some of the transitions around older age and transportation, transportation alternatives, and the type and frequency of trips taken.

One of the primary limitations of focus groups, however, is the difficulty in extending the results from the qualitative data to a larger population (Morgan 1997). To that end, the survey data we rely on, while providing less descriptive information about people's decisions, do allow us to generalize results to the population. Drawing on the information from the focus groups, we conducted a survey in spring 2002 of adult drivers aged 50 and older. Drivers were defined as people who were licensed to drive and had driven an automobile at least once in the previous twelve months. In order to capitalize on differences that emerged in the focus groups, the sample was stratified by age and gender. The sample was broken down into four age categories, with roughly equal numbers of men and women sampled within each of the following age groups: 50 through 59; 60 through 69; 70 through 79; and 80 and older.

A sample of 7200 adults aged 50 and older living in the United States were sent written questionnaires. This sample represented 4800 households headed by an individual 50 or older. The sample was selected from a pool of participants in an ongoing consumer marketing panel about whom we had some preliminary demographic information.³ A one dollar incentive to complete the extensive questionnaire accompanied each survey. The survey was mailed out on May 1, 2002, and in the field until June 3, 2002.

Of the 7200 questionnaires sent out, 3859 were returned completes for an effective individual response rate of 53.6%. Of these 3859 returned questionnaires, 35 of the responses

³ All of the respondents who received a questionnaire had previously agreed to participate in the panel and to receive questionnaires and surveys periodically. In this the sample population differs somewhat from the population as a whole. In addition, participants in the panel are more likely to be white and have higher levels of education than the population as a whole. To try to correct for some of these differences, the data are weighted to 2001 Current Population Study quotas on gender, age, region, household designation, and household size.

were from individuals younger than 50 years old, so these individuals have been eliminated from the analysis. Thus, in the survey data we have information on 3824 unique individuals. The data are weighted to 2001 Current Population Study (CPS) quotas to be representative of adult consumers aged 50 and older. The effective weighted individual sample size is 3819.⁴ The data were analyzed using SPSS.

Results

Focus Group Findings: Family First

The focus group results indicated, as the literature suggests, that there was a relatively high degree of self-awareness of changes in the driving experience with age, and most participants reported engaging in some degree of voluntary self-regulation of their driving in order to continue to feel safe while driving. The discussions explored whom people preferred to speak with about their driving abilities, should they need to cut back on their driving or to stop driving all together. Focus groups members generally preferred to be approached by individual family members as opposed to those outside the family (e.g., close friend, doctor or police). Participants indicated that outside professionals were likely to have little direct knowledge of their driving skills and ability, whereas family members who had ridden with the older driver would be in a much better position to make an assessment.

There were some gender differences around which family member should engage in the discussion. Some women felt a child who had their best interests in mind and who has also observed their driving would be best. Some men did not want their spouse to speak with them about driving. Also, although many older drivers admitted that they would likely feel initially

⁴ Most precisely, the sample is representative of adults aged 50 and older who live in households headed by someone 50 or older.

upset or angry when first approached, they encouraged family members to approach them multiple times to be effective.

Physicians generally shared the perspective of the older driver focus groups with respect to their role in decisions around driving. Although their formal roles vary by state, participants from the focus group prioritized their role as medical caregivers, not police officers.⁵ Respondents tended to agree that they would be more likely to initiate a conversation about driving with their patient if a serious medical condition existed (e.g., stroke, seizure, advanced cardiac disease, blindness or dementia), or if concerns had been expressed by family members (most frequently noted to be adult children rather than a spouse). Doctors reported that driving issues pertaining to older adults seemed to be presenting themselves more frequently at office visits. Interestingly, in spite of their reluctance to become engaged in such conversations, none of the physicians expressed concern about discussions around older driver safety having a negative impact on the doctor-patient relationship.

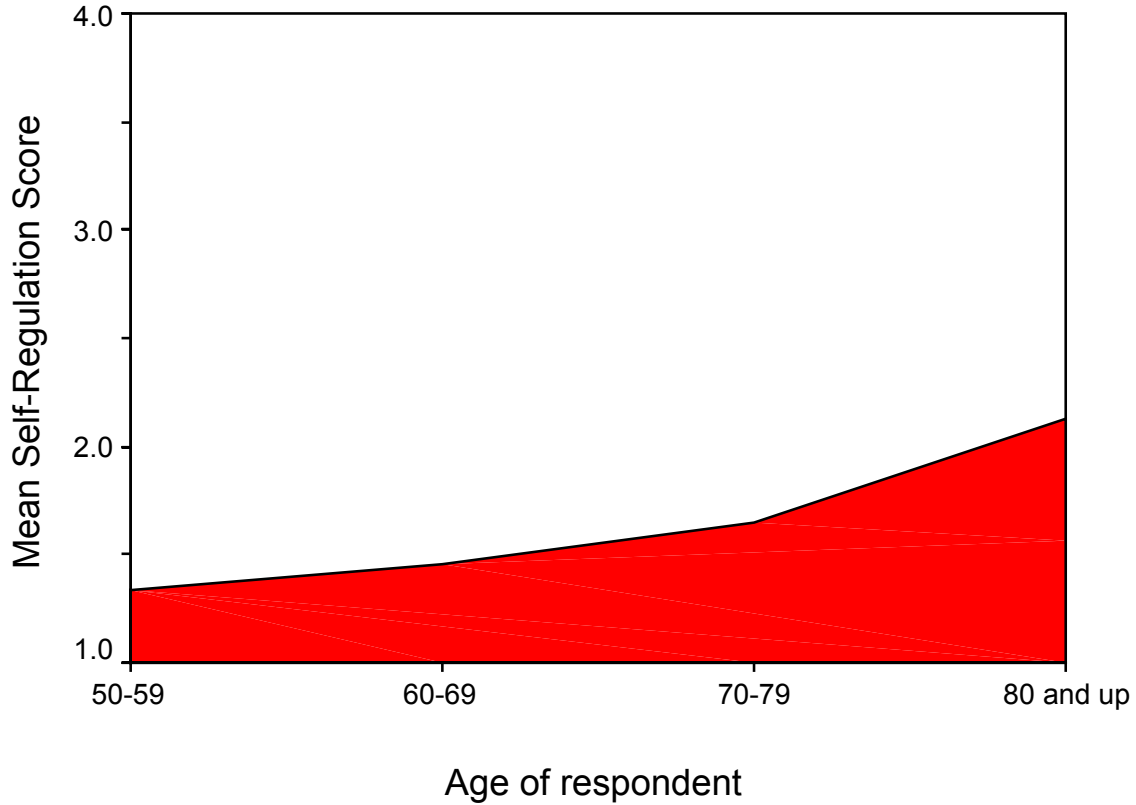
Survey Findings: Family First, but by a Smaller Margin

Survey respondents also indicated that they engaged in voluntary self-regulation around their driving in order to continue to drive safely. Figure 1 shows that people reported higher degrees of self-regulation with increasing age. Approximately 66% of our sample reported that they engaged in some degree of self-regulation. We also explored what people's preferences

⁵ States vary with respect to the laws they have and enforce about the role of physicians in the driving decision. In some states, such as California, doctors are mandated to report whether their patients are competent to drive, but anecdotal reports suggest that compliance with the law is irregular.

Figure 1

Self-Regulation of Driving Increases with Age



Self-regulation scale runs from a minimum of 1.0 to a maximum of 4.0.

Higher values indicate greater self-regulation.

were for making decisions around driving, by asking them about their experiences and opinions around such conversations. The results from the survey both complement and contradict the focus group data.

Table 1 presents the results of an item asking respondents to select the person they would be most likely to listen to about concerns over their driving, controlling for household arrangements. The data clearly show the impact on preferences of having a spouse in the household. Among those married with a spouse living in the household, half reported their

Table 1

**Person Identified as Most Likely to Be Listened to about Driving Concerns
by Household Status**

	Household Status	
	Married, spouse living in household	No other HH members
Spouse	50.0%	2.1%
Son	5.9	14.2
Daughter	8.4	17.0
Brother	.3	1.0
Sister	.2	2.9
Son-in-law	.2	.2
Daughter-in-law	.2	.2
Close friends	1.9	11.6
Doctor	31.0*	41.0
Other healthcare professionals	.7	2.1
Police	5.1	7.8
Number of cases	2137	540

Notes: Data are weighted.

* Respondents who incorrectly identified more than one person as someone they would be most likely to listen to were excluded from the analysis presented here, with one exception. In the case of married respondents, 31.0% of all married respondents reported that they would be most likely to listen to their doctor, as the table shows. When the sample for this item is made consistent with that for the other items, including only those who identified a single person as one whom they would be most likely to listen to, then only 27.1% of married respondents selected their doctor.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

spouse as the person they would be most likely to listen to about concerns about their driving.

Somewhat less than a third chose a doctor as the person they would be most likely to listen to, and only 14.3% indicated that they would be most likely to listen to an adult child. In contrast, 41.0% of those who live alone reported that they would be most likely to listen to a doctor about their driving. Nearly one third of these said an adult child would be their first preference.

People who live alone were also more likely to say that they would be most likely to listen to a close friend about concerns about their driving (11.6% of those who live alone, versus 1.9% of those married with spouse in household). The police were uniformly unwelcome as sources of conversation about concerns over driving.

Contextual factors also had an effect on whether adult children were more likely to be chosen as the person respondents would be most likely to listen to. Adult children were more likely to be chosen the older the respondent was, as Table 2 shows, perhaps reflecting the reality that those who are older would be more likely to be widowed. Regardless, the data indicate that the impact of adult children on decisions around driving should increase the older the driver. The survey also suggests that children who drive and who live nearby, within a 15 mile drive of their parents, are more likely to be selected than those who live farther away (adult child selected first for 26.2% of those who have a child living within 15 miles who drives, versus 14.2% of those who do not have a child living within 15 miles who drives, chi-square=71.416, $p < .001$, $N=3214$).

People offered different reasons for their preferences about whom to have a conversation with about their driving. Nevertheless, Table 3 shows that regardless of household status, the relative ranking of reasons to trust the person remained the same. The ranking of reasons changes, however, based on whom the respondent indicated he or she would be most likely to listen to. Table 4 displays the reasons to trust the person by the person chosen. Those who selected a spouse were most likely to report that they trusted this person because he or she sees or drives with the respondent regularly (77.4%), and has the respondent's best interests at heart (61.1%). Just over half – 53.8% – said that they chose a spouse because he or she knows whether the respondent is capable of being a good, safe driver. Those who selected an adult child were most likely to say that the child was selected because he or she had the respondent's best interests at heart (72.1%). Again, just over half – 55.3% – said that they chose a child because he or she knows whether the respondent is capable of being a good, safe driver. Yet over ninety percent (92.1%) of those who selected a doctor first reported that they did so because

Table 2

**Child Selected as First Choice for Conversation
about Driving Concerns by Respondent Age**

	Respondent Age			
	50-59	60-69	70-79	80 and older
	14.8%	19.8%	26.2%	31.7%
Number of cases	1348	857	629	281

Notes: Data are weighted.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

Table 3

**Reasons People Trust Another Person to Talk to Them about Their Driving
by Household Status**

	Household Status	
	Married, spouse living in household	No other HH members
Person knows whether I am physically capable of being a good, safe driver	61.4%	70.4%
Person has my best interests at heart	49.2	43.7
Person sees me or drives with me regularly	44.4	20.0
Person is a good driver and knows what they're talking about	26.0	18.1
Person is in a position of authority	10.6	13.7
Number of cases	2136	540

Notes: Data are weighted. Since respondents could choose more than one answer, percentages do not sum to 100.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

the doctor would know whether the respondent was capable of being a good, safe driver. These differences reflect the complexity that surrounds the driving decision for older adults. People have different preferences for and expectations about what criteria should be used to evaluate their continued driving and should weigh in the decision. These criteria, in combination with the sources available to them, drive their preferences for whom they would wish to talk to about

Table 4

**Reasons People Trust Another Person to Talk to Them about Their Driving
by Person Chosen**

	Person Most Likely to Listen to about Driving		
	Spouse	Adult child	Doctor
Person knows whether I am physically capable of being a good, safe driver	53.8%	55.3%	92.1%
Person has my best interests at heart	61.1	72.1	19.4
Person sees me or drives with me regularly	77.4	30.8	2.7
Person is a good driver and knows what they're talking about	37.8	35.1	2.6
Person is in a position of authority	6.1	2.9	9.8
Number of cases	1109	651	998

Notes: Data are weighted. Since respondents could choose more than one answer, percentages do not sum to 100.
Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

their driving.

We also asked people about the conditions under which they thought someone should talk to them about their driving. As Table 5 shows, regardless of household status, people's ranking of preferences was consistent. Respondents most frequently noted a significant change in their health as a condition that should trigger a conversation about driving, followed by general concerns about the respondent's safety. Incidents of forgetfulness or getting lost while driving ranked third as a spark for conversation.⁶ About half of the sample consistently reported that involvement in a serious accident should be a trigger for a conversation, and about one fifth of the sample said that involvement in a minor accident should be so. Respondents ranked near-

⁶ Forgetfulness or getting lost while driving in familiar places is a warning sign for Alzheimer's or other forms of dementia, and should thus be a clear trigger for a conversation about driving. Because we did not specify where these incidents might take place – for example, in a new setting or a familiar one – we suspect that many respondents did not interpret the item as we originally intended.

Table 5

**Conditions under Which People Felt Someone Should Talk to Them about Driving
by Household Status**

	Household Status	
	Married, spouse living in household	No other HH members
Generally concerned about my safety	73.3%	69.1%
After a significant change in health	73.9	76.3
Incidents of forgetfulness or getting lost while driving	71.6	67.7
Narrowly avoided being in an accident	29.1	27.8
Involved in minor accident	17.8	20.0
Involved in serious accident	49.7	55.8
Number of cases	2015	540

Notes: Data are weighted. Since respondents could choose more than one answer, percentages do not sum to 100.
Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

misses, or narrowly avoiding being involved in accident, as more important triggers for a conversation than involvement in minor accidents.

We also asked respondents whom they absolutely would not want to be involved in a conversation about their driving. These results are in Table 6. The police are most people's first choice from whom they do not want to hear. About one fourth of all respondents reported they would absolutely not want the police to talk to them about their driving. It is interesting to note, however, that spouses constitute a significant minority category of those people would prefer not to hear from. Among those who were married with a spouse living in the household, 18.4% reported that they would absolutely not want to hear from a spouse. This suggests that while in a majority of cases, a spouse, when available, is a good choice as a source to initiate a conversation about driving concerns, the preference is not universal. Apart from this, people's resistance to hearing from other parties is roughly equal across categories.

We also asked respondents whether they themselves had had someone initiate a

Table 6

**Source Identified by Respondent as Someone They Would Absolutely Not
Want to Have Talk to Them about Their Driving
by Household Status**

	Household Status	
	Married, spouse living in household	No other HH members living in household
Police	25.0%	26.1%
Spouse	18.4	6.3
Close friend	12.2	15.2
Daughter-in-law	13.1	11.0
Son-in-law	12.1	9.9
Daughter	11.6	9.2
Son	9.6	9.0
Sister	9.0	9.2
Brother	8.7	8.4
Other healthcare provider (not doctor)	8.8	10.2
Doctor	5.4	3.9
Number of cases	2137	540

Notes: Data are weighted. Since respondents could choose more than one answer, percentages do not sum to 100.
Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

conversation with them about their driving. Only 2.2% of our sample (82 respondents, data weighted) reported that they had. While this percentage seems extremely low, it may not be a true indicator of the extent of these types of conversations with older adults around driving. First, since our sample consists of drivers, we do not know to what extent conversations such as these would have been the trigger for people who gave up driving all together. It may be that such conversations are more likely when the situation is most dire – when there are no real choices around continuing driving safely. It could also be that respondents underreported these data, perhaps being unwilling to admit that there could be concerns over their driving. Finally, it is possible that what others took to be a discussion about their driving the respondent interpreted otherwise, perhaps just as casual conversation. Regardless of the reason, however, these data should be interpreted with caution. The number and percentage of people who reported that they

had been approached about their driving are very small, and this sub-sample is too small to generalize to the whole population reliably.

Men were more likely to have been spoken to about their driving than women. 60.3% of those spoken to were men, while only 39.7% were women. The majority of those spoken to – 76.8% – were married, with a spouse living in the household.⁷ The distribution of those spoken to by age was U-shaped. 35.6% of those spoken to about their driving were 50-59, compared with 12.3% for those 60-69, 17.8% of those 70-79, and 34.2% of those 80 and older. In addition, people who were in poor health were more likely to report that someone had spoken with them about their driving. 7.1% of those in poor or fair health reported that someone had spoken to them with concerns about their driving, compared with 1.1% of those in good, very good or excellent health (chi-square=67.027, $p < .000$, $N=3106$).

When we asked people who had approached them about their driving, the results echoed people's preferences, as shown in Table 7. Spouses were participants in discussions for 46.8% of respondents. Adult children also figured prominently, with adult daughters more likely than adult sons to have been party to the conversation. The differences between the roles of adult daughters and adult sons, however, are most stark among women. Among older women who reported that someone had approached them about their driving, 25.8% reported that their adult daughters had done so, whereas only 3.2% reported that their adult sons had done so. Somewhat surprisingly, the survey data reveal that 43.2% of those in the sample who had been approached about their driving reported that a doctor had been a participant in the conversation. This number seems quite high, given the reluctance physicians expressed in the focus groups to

⁷ Because there are so few cases where people reported being spoken to about their driving and living alone with no other household members, the data in this discussion are not compared along household status. We do, however, present the data by gender to explore whether any gender differences were manifest in such discussions.

Table 7

**Who Spoke to Respondent about Their Driving,
Overall and by Gender**

	Overall	Gender	
		Men	Women
Spouse	46.8%	46.8%	43.3%
Son	16.3	23.9	3.2
Daughter	30.1	31.9	25.8
Brother	5.4	4.3	3.3
Sister	3.5	6.4	0
Son-in-law	5.8	8.5	3.3
Daughter-in-law	5.9	8.5	0
Close friends	9.0	4.3	12.9
Doctor	43.2	41.3	43.3
Other healthcare professionals	7.1	6.4	6.5
Police	4.3	6.4	0
Other	1.0	2.1	0
Don't know	10.3	13.0	6.5
Number of cases	82	47	30

Notes: Data are weighted. Table includes only those respondents who reported that someone had approached them with concerns about their driving. Since respondents could choose more than one answer, percentages do not sum to 100.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

become involved in such a decision. Aside from repeating the caution about drawing generalizations from these data, however, the high percentage of people who reported that a doctor had been involved in the conversation may indicate that this group may be more likely to have more significant health issues. Doctors should be more likely to raise the issue of driving in those cases where the individual's health presented an obvious and clear hazard to continued safe driving.

Table 8 displays the results of an item asking people about the content of their conversations about driving. In particular, we wanted to know what older drivers had been asked by others to do. The majority of requests involved cutting back a little bit on driving, or on driving under certain conditions. Still, over one-fifth of this group – 21.8% – was asked by

Table 8

**What Were People Asked to Do about their Driving,
Overall and by Gender**

	Overall	Gender	
		Men	Women
Cut back a little bit on driving	46.6%	40.0%	41.9%
Cut back on certain types of driving	29.4	28.3	29.0
Take a defensive driver or refresher class	2.3	4.3	0
Have a formal test or evaluation done	4.2	6.5	0
See a doctor	6.4	6.4	6.7
Get a different car to drive	4.2	2.2	6.5
Stop driving all together	21.8	21.3	20.0
Number of cases	82	47	31

Notes: Data are weighted. Table includes only those respondents who reported that someone had approached them with concerns about their driving. Since respondents could choose more than one answer, percentages do not sum to 100.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

others to stop driving all together. These three types of requests accounted for the vast majority of conversations; few gender differences existed between the types of requests made of older adults.

We asked those who had been spoken to about their reactions to the conversations. Table 9 displays these results. Just 6.4% of men reported feeling angry in reaction to the conversation, while 12.9% of women did.⁸ Feeling depressed was the most frequently mentioned emotional response, overall and by both men and women, followed by feeling sad. Table 9 also shows that in this sample of respondents, compliance was generally high; 59.6% of all these respondents said that they had listened to what the other person had said and did as was suggested. Women were more likely to comply with suggestions, and less likely to ignore the person or decide they were not right, than men were. Health status also played a role in people's reactions to the

⁸ We again caution against drawing firm generalizations based on the size of this sub-sample of those who have been spoken to about driving.

Table 9
Reactions to Being Spoken to about Driving,
Overall and by Gender

	Overall	Gender	
		Men	Women
Angry	9.3%	6.4%	12.9%
Felt guilty	2.4	0	3.3
Felt sad	10.8	10.6	12.9
Felt depressed	15.9	14.9	16.7
Ignored them	7.3	4.3	6.5
Listened to what the person said but decided they weren't right	16.0	21.3	10.0
Listened to what the person said and did as suggested	59.6	55.3	67.7
Other	1.5	0	3.3
Don't know	7.9	8.7	6.5
No reactions	1.6	2.2	0
Number of cases	82	46	31

Notes: Data are weighted. Table includes only those respondents who reported that someone had approached them with concerns about their driving. Since respondents could choose more than one answer, percentages do not sum to 100.

Source: The Hartford-MIT AgeLab Older Driver Survey 2002.

conversation. Of those spoken to, people in less good health were more likely to report more negative emotional responses to the conversation. 38.9% of those in poor or fair health reported one or more negative emotional reactions to the conversation, while only 18.4% of those in good, very good or excellent health reported one or more negative emotions (chi-square=3.810, p=.051, N=74).

Implications

The qualitative and quantitative studies here underscore once again the delicacy of the subject of driving. Driving is integral to people's conceptions of themselves, their independence, and their mobility. The loss of a driver's license is the loss of a lifestyle. As a society, reliance on the personal vehicle for transportation has never been higher, and this trend seems unlikely to

change in the near future. Yet the aging of the population makes the issue of keeping older adults on the road and driving safely a pressing one. The role of others in decisions around older adults' driving will likely only become more important. Our results indicate that people most often prefer family members, notably spouses when available, to initiate such a conversation. Adult children were also valued as sources of input. Yet these choices were not universal; over 18% of those who were married with a spouse in the household reported that they absolutely did not want to hear from their spouse about driving concerns.

Doctors were also selected as preferred conversation partners by about a third of the sample and were the only non-family members appearing to have significant influence over older drivers. But physicians themselves are often reluctant to be party to such a decision. Older drivers' assumptions that doctors can and will provide advice combined with doctors' reluctance to become involved creates a wide gap where safety can be compromised.

In addition, our focus groups with older drivers, as well as the results in Table 3, suggest that people valued input from those who had direct knowledge and experience with their driving. These data, taken together, suggest that families need to evaluate their own situations carefully, in addition to the preferences of the older adult, to decide who might best aid or support an older driver in his or her decisions around driving. Families might consider working with doctors around the impact of health issues and driving behaviors to help older adults make good, safe driving decisions. The results are clear, however, in that older adults do not wish to hear from police officers about concerns over their driving.

Conversations and decisions around the driving behaviors of older adults might also emphasize that the ultimate goal is balancing safety with independence. Table 3 shows that a significant portion of our sample reported that they trusted someone to talk to them about their

driving because that individual was likely to have the older driver's best interests uppermost. Older drivers also indicated that they were open to conversations when others were generally concerned about their safety, or after a significant health change might make them more vulnerable. Developing a relationship and a history that make clear a concern for the older adult's safety and health may help to pave the way for more productive conversations around driving decisions.

Only a small portion of our sample reported that they had been approached by others about their driving behaviors. This, in conjunction with the relatively high involvement of doctors in the discussion, underscores once again the delicacy of the subject matter. These data support the notion that people avoid conversation with older drivers about their driving concerns perhaps until the problem becomes a more significant one that can no longer be ignored. Earlier conversations may provide more time for thoughtful skill assessment, potential driver rehabilitation, or family adjustment to a new transportation support role. Overall, this group was generally compliant with others' requests, and did not report reacting with a great deal of anger, guilt, sadness or depression. The data do provide some hints that conversations that raise specific, limited issues may be received somewhat more positively than broader discussions around cutting back on driving. Families should be sensitive to their own situations, and recognize that the reactions of older adults in their families may differ significantly from those presented here.

Conclusions and Future Research

Decisions around limiting or stopping driving are among the most difficult that older adults may have to face. Families can clearly play an important role in these decisions, both

through supporting older adults' voluntary self-regulation of driving, and by helping older adults who need it to make decisions to cut back or cease driving. By and large, older adults prefer to have families involved in this difficult and sensitive process, notably spouses and adult children, but this is not universal and families need to be aware of the dynamics in their particular situations. Physicians also tend to be accorded influence in making such decisions, but this is again not uniform throughout the population, and doctors themselves may be unwilling or ill-prepared participants.

The issue of driving is just one context in which older adults may be called upon to make difficult choices. As the population ages, however, we can expect similar questions also linked to feelings of autonomy to come to the fore. For example, how long may older adults be able to live independently, in their own homes? At what point do or should families and others become involved in the decisions around living arrangements older adults make? What about decisions around health and medical treatment, or issues such as long-term health care and financial planning? The results presented here merely underscore the delicacy and complexity involved in making decisions such as these, but also raise additional questions. Future research might address more systematically the degree of influence others, such as specific family members and physicians, have on the decisions older adults make. It might also address how this influence varies by context and by individual differences, such as health, among older adults. More broadly, we might consider whether the role of others in making difficult decisions varies with age and life stage, and the ways in which we can support older adults in making good, effective choices that enable them to maintain their independence, autonomy and quality of life as long as they are able.

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