Older Adults’ Health Information Wants in the Internet Age: Implications for Patient–Provider Relationships

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A qualitative, exploratory study was conducted in the summer of 2007 to investigate older adults’ preferences for health information and participation in decision making. The study involved in-depth individual and focus group interviewing with a total of 20 older Internet users and nonusers. Grounded theory was used to conduct the data analysis and construct the theory that best explains the data. The concept of health information wants (HIW), or health information that one would like to have and use to make important health decisions that may or may not be directly related to diagnosis or standard treatment, emerged from the data analysis and led to the development of the HIW framework. This framework encompasses four types of HIW that have varying properties and positions on the decision-making spectrum. While Internet use has not changed these older adults’ reliance on medical professionals for diagnostic or standard treatment decisions (and reliance on professionals for information needed to make those decisions), it has opened up new venues for obtaining information to make decisions in broader scopes. Thus, both the Internet and the perpetuating influence of the provider–dependent model are at play in the patient–provider relationships of these older adults.

Older adults typically have greater needs than younger adults for health information, yet those needs often are unmet through conventional channels (Wicks, 2004). The Internet has become an important means for disseminating health information (Fox, 2006; Kaiser Family Foundation, 2005) and aiding health decision making (Fox & Raine, 2002). There has been much general discussion about the impact of the Internet on patient–provider relationships (Blumenthal, 2002; Gerber & Eiser, 2001; Wald, Dube, & Anthony, 2007). Little is known, however, about how the Internet affects the relationships between providers and older adults, who, unlike younger people, have lived through the transition from a provider-dependent (paternalistic) to a shared or informed decision-making approach to health care (Brody, 1980; McNutt, 2004). This study aims to address this gap.

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Information-Seeking and Decision-Making Preferences

Since the 1970s, expectations for patient–provider relationships have changed substantially (Brody, 1980; Jones & Phillips, 1988). While a few decades ago patients were expected to be passive recipients of medical care and doctors were expected to be making all the decisions, patients now are encouraged to play a more active role in their own medical care decision making (Ballard-Reisch, 1990; McNutt, 2004). This paradigm shift in the patient–provider relationships has generated much interest in patients’ information-seeking and decision-making preferences (Benbassat, Pilpel, & Tidhar, 1998).

A common theme has emerged from this line of research: while patients are universally and overwhelmingly interested in having detailed information, only to a much less extent and with greater variation do they want to participate in decision making, suggesting a discrepancy between information-seeking and decision-making preferences (Cassileth, Zupkis, Sutton-Smith, & March, 1980; Deber, Kraetschmer, & Irvine, 1996; Degner & Sloan, 1992; Ende, Kazis, Ash, & Moskowitz, 1989; Gaston & Mitchell, 2005; Hill & Laugharne, 2006; Robinson & Thomson, 2001; Strull, Lo, & Charles, 1984). Several important questions arise:

- Why are patients less interested in participating in decision making?
- Why do patients want more information than they need to make decisions? And,
- What do patients intend to do with the—seemingly “excessive”—information once they obtain it?

Research to date largely has focused on examining patients’ lower level of desire for participation in decision making (Benbassat et al., 1998; Gaston & Mitchell, 2005). Several factors have been reported to be predictive of decision-making preferences:

- the severity of illness (Deber et al., 1996; Degner & Sloan, 1992; Ende et al., 1989; Ende, Kazis, Ash, & Moskowitz, 1990; Hill & Laugharne, 2006);
- the role of being a patient (Ende et al., 1990);
- cultural norms and expectations (Baider, Ever-Hadani, & Kaplan, 1995; Blackhall, Murphy, Frank, Michel, Azen, 1995; Young & Klinge, 1996);
- sociodemographic factors (Davison, Gleave, & Goldenberg, 2002; Degner et al., 1997; Rees & Bath, 2001; Silliman, Troyan, & Guadagnoli, 1997; Turk-Charles, Meyerowitz, & Gatz, 1997); and
- personality (Braman & Gomez, 2004; Flynn & Smith, 2007).

Despite all these attempts, still, a large proportion of the variability remains unexplained (Benbassat et al., 1998; Braman & Gomez, 2004; Ende et al., 1989). Further, while these studies provide some answers to the question of why patients do not want to participate in decision making, they cannot, as Bagley-Burnett (2004) correctly points out, help with the questions of why patients want information even when they do not want to use it to make decisions, and what patients intend to do with the information after they obtain it.

Recently, research on information-seeking and decision-making preferences has been extended to the online world. Much research, however, has focused only on information seeking related to either the sociodemographic and situational characteristics of online health information seekers (Bundorf, Wagner, Singer, & Baker, 2006; Fox, 2006, 2007; Hardt, 2007) or on the types of health information sought online (Fox, 2006, 2007; Morahan-Martin, 2004). Much less emphasis has been
placed on decision-making preferences, and even less emphasis on examining the intersection between the two. The handful of studies examining information seeking and decision making simultaneously have reported mixed results. Some find that online information seeking is positively associated with increased participation in decision making (Bass et al., 2006; Fox, 2007; Fox & Raine, 2002). Others fail to find connections between these two variables (Baker, Wagner, Singer, & Bundorf, 2003; Dickerson et al., 2004; Flynn, Smith, & Freese, 2006; Fox & Raine, 2000), however, thus duplicating the discrepancy between information-seeking and decision-making preferences as reported in studies that were done before Internet health information became so prevalent.

Despite these gaps in the literature, one fact has been well established: age is negatively associated with both information-seeking and decision-making preferences (Benbassat et al., 1998; Hill & Laughrane, 2006; Maibach, Weber, Massett, Hancock, & Price, 2006). Age-related changes in cognition (Finucane, Mertz, Slovic, & Scholze Schmidt, 2005) and emotional processing and motivation (Lockenhoff & Carstensen, 2007) have been shown to have effects on older adults' decision-making. To date, however, relatively little is known about the relationship between older adults' information-seeking and decision-making preferences, or how Internet use may (or may not) compensate for age-associated barriers to information seeking and decision making. This study aims to generate new insights into the interplay among age, Internet use, information seeking, and decision making in health care.

Key research questions included the following:

- What types of health information do older adults want?
- Why do older adults want each of these types of information?
- What are older adults' perceptions and use of the Internet as a source of health information?

Methods

Participants

A total of 20 older adults participated in this study (Table 1).

Procedure

Recruitment flyers were posted at two public libraries and one senior center in Maryland to invite older adults aged 60 and above to participate. Fourteen semistructured, open-ended interviews of 45–60 minutes and one focus group of six participants of 90 minutes were conducted during the summer of 2007. Each participant completed an informed consent form prior to data collection. All interviews were recorded. Each participant received $30 in cash for participation.

Interview Questions

Interview questions focused on three major aspects:

- Health information-seeking behavior (Exemplar questions: During the past 3 months, have you needed or wanted to find out any health information? What? From what source? And for what purpose?);
General usage of computers and the Internet (e.g., Have you used the computer? The Internet? For how long?); and

Perceptions and use (or nonuse) of the Internet for health information (e.g., In your opinion, is the Internet a good place to look for health information? Why? Have you personally tried to look for health information on the Internet? How was your experience?).

Data Analysis

Guided by grounded theory (Strauss & Corbin, 1998), the author coded and memoed the text after audio interview data were transcribed into text (by a paid transcriber). The memos were used extensively to document or “bracket” the author’s self-reflections on her own influence on the data collection and analysis (Ahern, 1999; Hall & Callery, 2001). This strategy, combined with triangulation of multiple data collection and analysis methods, helped to establish credibility (internal validity) of the findings (Winkelman, Leonard, & Rossos, 2005).

The first individual interview and the focus group interview data were analyzed by using the techniques of microanalysis or “detailed line-by-line analysis” (Strauss & Corbin, 1998, p. 57). This involved conducting open coding to identify salient core concepts, followed by axial coding to systematically explore the properties and

| Table 1. Age, gender, race/ethnicity, education, income, and computer experience of participants |
|---------------------------------------------|--------------|
| Demographics                                | Number (%)   |
| Age                                         |              |
| 60–69                                       | 8 (40)       |
| 70–79                                       | 10 (50)      |
| 80 or older                                 | 2 (10)       |
| Race/ethnicity                              |              |
| African American                            | 4 (20)       |
| Latino                                      | 1 (5)        |
| White                                       | 15 (75)      |
| Gender                                      |              |
| Women                                       | 11 (55)      |
| Men                                         | 9 (45)       |
| Education                                   |              |
| Less than high school                       | 1 (5)        |
| High school                                 | 5 (25)       |
| At least some college                       | 14 (70)      |
| Yearly household income                     |              |
| Less than $20,000                           | 6 (30)       |
| $20,000–$39,999                             | 4 (20)       |
| More than $60,000                           | 6 (30)       |
| Do not know or wish to answer               | 4 (20)       |
| Computer use                                |              |
| Yes                                         | 15 (75)      |
| No                                          | 5 (25)       |

- General usage of computers and the Internet (e.g., Have you used the computer? The Internet? For how long?); and
- Perceptions and use (or nonuse) of the Internet for health information (e.g., In your opinion, is the Internet a good place to look for health information? Why? Have you personally tried to look for health information on the Internet? How was your experience?).
dimensions of the core concept and its subcategories. Results of the microanalysis of the initial interviews guided the selection of remaining participants, a process called theoretical sampling. By deliberately seeking out and including participants of varying characteristics and perspectives, this sampling strategy helped to establish the transferability (external validity) of findings (Cutcliffe, 2000; Mays & Pope, 1995; Winkelman et al., 2005).

The microanalysis of the first several interviews focused on detecting new concepts and thus relied more on open coding than axial coding. Using the coding scheme that emerged in the previous analysis, axial coding was used more heavily during the middle stage of analysis. This allowed the author to focus on enriching the existing core concept, its subcategories, and their properties and dimensions while at the same time continuing to be sensitive to emerging concepts. When theoretical saturation was reached, the remaining stage of data analysis then relied primarily on selective coding to integrate and refine categories to form theory. At this stage, commonalities and differences in the properties and dimensions of the subcategories were further sought and explanations were formulated. Meanwhile, a thorough literature review was used to help situate the data-driven explanations in existing literature (Cutcliffe, 2000). Finally, the theory that could best interpret the data was written.

An independent researcher—who is an expert in qualitative interviewing and grounded theory but was uninvolved in this study—analyzed the transcripts of four randomly selected interviews by following the same data analysis procedure described above. This independent researcher’s analysis generated similar concepts, demonstrating dependability (reliability; Cutcliffe, 2000; Winkelman et al., 2005) of the findings.

Results

The concept of HIW, or health information that one would like to have and use to make important health decisions that may or may not be directly related to diagnosis or standard treatment, quickly emerged from the initial data analysis. Four types (subcategories) of HIW are subsequently identified:

- Type 1 (basic HIW): very general, basic information about specific conditions and treatments to help to cope with the stressful situation;
- Type 2 (advanced HIW): detailed information about every aspect of specific conditions and (standard) treatments to prepare to understand and monitor doctors’ decisions;
- Type 3 (complementary HIW): information about complementary/lifestyle treatments to make decisions about nonstandard treatments; and
- Type 4 (provider-related HIW): information about health care providers to make decisions about which provider to choose.

These four types of HIW vary along the spectrum of decision making and represent different perceptions of patient–provider relationships. On one end of the spectrum, Type 1 HIW features great dependence on professionals and little participation from patients in making decisions regarding diagnosis or treatment. This type of health information is not intended to be used to make diagnostic or treatment decisions. On the other end of the spectrum, Type 4 HIW represents a high degree of patient autonomy as participants gather information to make decisions about providers and,
consequently, diagnosis and treatment. Meanwhile, Type 3 and Type 2 HIW that feature—more or less, overt or potent—joint decision making by both the patient and the professional are located in the middle of this spectrum. While doctors may not be the ideal source to meet these four types of HIW, the Internet has the potential to do so (Figure 1).

**Type 1: Basic HIW**

Some participants wanted very basic information that can give them a general understanding of their conditions and treatments. This type of information is not intended to be used for diagnostic or treatment decision making: Participants generally are happy with the diagnostic or treatment decisions made by doctors and accept or plan to accept those decisions. They do want information that can help them to know what to expect, however, so that they can better cope with the stressful situation. For instance, participant 13, who is scheduled to have surgery a month later for repair of two large tears in the rotator cuff at her right shoulder, says:

I would like to see a picture of the rotator cuff and I’d like to know exactly what it does and what it will be able to do after the surgery. . . . It doesn’t matter if I know them, but I’m curious. I want to find out about the rotator cuff, but the surgery is not going to depend on what I find out.
Clearly, this patient does not need to have this information to make diagnostic or treatment decisions. Having such information, however, can help the patient to make decisions about aspects of life that will be unavoidably affected by a diagnosis or treatment so that the patient can better cope with the stressful situation arising from a particular diagnosis or treatment. In this type of situations participants have complete, unquestionable faith and trust in the expertise and authority of medical professionals and depend entirely on professionals to make diagnostic and treatment decisions. Thus Type 1 HIW is related to a desire for making decisions to better cope with the decisions made by professionals.

While relying completely on professionals to make diagnostic or treatment decisions, when this type of HIW arises, participants do not rush to professionals to obtain the information. A main reason is that, as participant 1 explains, “It does not concern me such that I want to go and make a special appointment…. I don’t have a crying need to find it out.” Instead, participants are likely to wait until the next regular appointment with a doctor to try to obtain the information, although, to use the words of participant 9, “during this time it would be good to be able to go to the Internet and see if there is anything on the Internet.” The convenience and availability of the Internet makes it a good option for meeting this type of HIW. As participant 6 states, “It’s just so much easier to get to than having to go to a doctor.”

Type 2: Advanced HIW

Some participants wanted detailed, up-to-date information about a specific condition or treatment. Participants want this type of information not because they want to make these decisions—they still want doctors to make the diagnostic or treatment decisions. Having this type of information, however, helps them to feel that they are better prepared to interact with doctors in the sense that they can better understand what doctors say and, further, perhaps—very gently—dropping “a hint” to remind a doctor (about, for instance, a possible diagnosis or treatment), just in case the doctor might happen to have neglected it. As participant 15 states:

It helps if you are as knowledgeable as you can [be] when you are presented to the doctor. You can give your doctor a hint that you think this might be what’s going on, and he would say it is or it isn’t. If you’re more knowledgeable, you can help your doctor; he can help you better if you’re more knowledgeable.

Being more knowledgeable thus can help the patient to be able to monitor the decisions made by a doctor. As participant 11, who “feels much more empowered” because of the information he has been able to obtain from the Internet, states, “Now I can question medical people on the basis of knowledge…. I can ask semi-intelligent questions, and if they can’t give me semi-intelligent answers, I’m going to go somewhere else.” In this situation participants begin to have reservations about the expertise of professionals. They want to be better prepared—just in case professionals are not. Type 2 HIW represents a higher level of participation in decision making.

There is a consensus among the participants that doctors are not necessarily the best source to meet this type of HIW, mainly because doctors often do not make
much effort to explain everything. As participant 20 complains, “I don’t think doctors are a very good source of information because they write it and they say, ‘take this and goodbye.’” Similarly, participant 10’s experience is that “doctors don’t tell you a great deal; you have to really pull it out of them.” Even when doctors do try to explain, participants often find that their explanations are too technical to understand. Participant 11 reported with frustration, “I think my doctor and I spoke on a level that seemed like I knew what he was talking about.” Many participants are pleased that the Internet provides more general or lay information that is easier for them to understand: “The Internet gives me short articles that I can read immediately—the reasons, names, side effects…. I don’t want to be deep in the problem” (Participant 14).

**Type 3: Complementary HIW**

Some participants wanted information about complementary or lifestyle treatments such as diet and exercise. They want this type of information so that they can engage in helpful activities that doctors may have neglected to mention. This type of information is not intended to be used to replace diagnostic or (standard) treatment decisions made by doctors. Rather, it is used to complement doctors’ decisions. For instance, participant 14 explains:

> I would normally leave the diagnosis to the doctors, let them decide. And then, after they diagnose whatever medical condition, I try to just help doctor, help myself—not use too much medicine—but help if I can find some other ways such as diet and exercise.

By making decisions about complementary treatments, participants exhibit more direct participation in their own health care. In this situation participants openly express their understanding of the inherent limits of medical professionals (i.e., most doctors are not trained to be experts in complementary treatments). As participant 8 points out, “There is now a whole area of dietary supplements that is not directly related to what physicians do. The physicians are not going to tell you about dietary supplements—they don’t know themselves. Doctors don’t know every answer.”

Not surprisingly, participants turn to other sources such as the Internet to obtain this type of information. Further, because of the complementary nature of this type of information, participants generally have less concern about the information they obtain from the Internet than they would have if the information were about more critical things (e.g., what medicine to take). Participant 9 explains:

> If you went on the Internet and you wanted to find something out about your circulation problem, and it told you to take medicine, I would be very concerned…. But if it told you some physical therapy that would help that problem, that wouldn’t concern me.

Further analysis suggests that among these participants there is usually a closed circle of information-seeking/verifying process that circulates between the doctor and the Internet. For instance, when asked if she had any concerns about using the Internet for medical information, participant 12 said “no,” because “I wouldn’t use the Internet entirely. I would check with my doctor in addition to the information
I got from the Internet.” Thus, in the minds of these older adults, (1) information about what medicine to take is more critical than that about, for instance, diet, or physical therapy; (2) critical decisions should be left to doctors; and (3) although the Internet can provide information to make less critical decisions (e.g., complementary treatments), still, doctors are the primary source for critical information and decision making.

Type 4: Provider-Related HIW

Some participants wanted information about the credentials and reputation of a provider—so that they can make better decisions about which doctor or facility to use. A main reason that participants may want this type of information is that they had a bad experience with a particular provider. Participant 11 recalls how, one time, he was dissatisfied with a surgeon because that surgeon did not appear to be as knowledgeable as he should be:

> When my wife had the ovarian cancer, I became relatively knowledgeable about it. When we went to a surgeon, I asked the surgeon some questions and determined very quickly that I knew more about it than he did, and we just walked out.

Because this surgeon was recommended to them by their family doctor, they did not want to go back to the same family doctor for information about whom else to see. Luckily, this participant was able to find information about the best providers in the area through the Internet:

> I went to the web, and I looked up... I found the list of names of the top-rated oncologists in the area, and the same way with [the top-rated] medical centers... As a result we talked with the top doctors at one of the top centers in this area.

Being able to use a source other than doctors to obtain necessary information to make decisions about which doctor to see—and, subsequently, what diagnosis to have and what treatment to use—is an important approach to patient empowerment. Participant 20 explains how much he appreciates the Internet as an alternative information source:

> When I grew up, you go to the doctor, do what he says, and take the medicine he gives you, and just believe; don’t ask questions, just do it.... Things are [done] a little bit differently these days. In the past doctors were accepted on faith, but now you could have a dialog with a doctor.

In the Type 4 situation participants exhibit great autonomy in that they seek information about the credentials and reputation of providers and then make decisions about which provider to go to. While participants ultimately still may delegate the diagnostic and treatment decision-making authority to professionals, the decision about which professional should be selected to be the delegate is made independently by participants. Thus, this type of HIW is related to making decisions not only about providers but also about diagnosis and treatment.
Discussion

This study investigates the reasons behind the widely circulated but previously largely unexplained discrepancy between patients’ information-seeking and decision-making preferences. The findings led to the construction of the HIW framework, which provides a fresh approach to explain this discrepancy. Key to this fresh approach is an understanding that decision making is a spectrum that includes not only treatment but also other types of decision making (that previously were under-studied), and that a desire for different types of health information is associated with a desire for different types of decision making.

In the Type 1 situation, although information is not used to make direct diagnostic or treatment decisions, it is nonetheless useful in helping to know what to expect and how to cope, which can lead to a reduced level of uncertainty and negative affect (e.g., anxiety) associated with the stressful situation (Kuhlthau, 1993, 2004; Lazarus & Folkman, 1984). In the Type 2 situation, information is not openly intended to be used to replace doctors’ decisions, yet it reflects a potent need for diagnostic and treatment decision making: Patients want to be prepared so that they can understand and monitor the diagnostic and treatment decisions made by doctors. Recognizing these types of HIW thus helps to explain why people want information even when they do not plan to use it directly or openly to make diagnostic or treatment decisions.

A quick comparison of the Type 3 and Type 4 HIW with existing instruments (Cassileth et al., 1980; Ende et al., 1989; Krantz, Baum, & Wideman, 1980) reveals that these two types of HIW—and the decision making associated with them—are not measured in these existing instruments. This may reflect a methodological limitation of previous research: In studying the health information behavior of patients, a common methodological approach is to survey patients using instruments that include a set of predetermined, close-ended questions. There is evidence that the selection of survey questions is heavily influenced by professionals who study or serve patients (e.g., academics, health care professionals; Ende et al., 1989). Because professionals often have different backgrounds and perspectives than the populations they study or serve (Hassol et al., 2004; Jones, 1986; Laine et al., 1996; Masys, Baker, Butros, & Cowles, 2002), it is likely that this methodological approach has limited the findings. In comparison, research that elicits and analyzes open-ended, free responses can reveal valuable information about patients’ self-perceived information needs that otherwise may be overlooked (Jones, Morrow, Morris, Rites, & Wekstein, 1992). By conducting in-depth interviews and carefully following the grounded theory approach to analyze the data, this study enabled older adults to speak for themselves in terms of what types of information they would want and thus was able to reveal previously unmeasured types of HIW.

Another possible reason that these HIW previously were unmeasured, however, may be that, in the past, it was not common for the general public to have easy access to information about, for instance, the credentials of a particular doctor. Thus, it was not as necessary to measure these types of HIW and the associated decision making. The Internet makes it possible to obtain such information with relative ease (Campbell, 2001). Thus, it is now more common that patients can make decisions regarding providers and complementary choices (Fox, 2006). Research instruments will need to be revised to reflect the impact of the Internet in this regard.

The identification of these four types of HIW among the participants also helps reveal an interesting absence of desire for participation in diagnostic or treatment
decision making: These older adults, Internet users or not, still primarily rely on
doctors to make decisions about diagnosis and (standard) treatment. This suggests
that Internet use, while enabling new forms of participation in decision making,
has not changed patients’ reliance on providers for these types of decisions, which
are at the core of the conventional patient–provider relationships (Makoul, 1998).
Other studies report similar results (Hardt, 2007; Kaiser Family Foundation,
2005), suggesting the validity of this finding across various groups of older adults.
One possible reason is that, although the Internet can help narrow the expertise
gap between patients and providers, it does so only to a certain extent (Bylund,
Sabee, Imes, & Sanford, 2007). This may be true especially among older adults,
who tend to have poor online searching skills and thus often have difficulty finding
relevant health information online (Bundorf et al., 2006; Fox, 2006; Xie, 2008).

Another possible reason for these participants’ reliance on doctors may lie in the
conventional medical model, which holds that patients essentially are passive recipients in medical encounters (Brody, 1980). Having been more heavily influenced by
this model, older adults are more likely than their younger counterparts to exhibit
greater “perpetuating passivity” (Makoul, 1998). An interesting question is how
Internet use might interact with the influence of this model. Already there is evidence
that some people—mostly younger adults—use the information they found online to
replace visits to doctors’ offices (Fox & Raine, 2002; Fox et al., 2000). Medical
professionals, however, “continue to offer genuine technical competence that will
be difficult, or impossible, to replicate from other sources” (Blumenthal, 2002,
p. 543). Further, even narrowing the expertise gap cannot change providers’ legitimate authority for keeping people healthy (Bylund et al., 2007). In the foreseeable
future, online health information will likely be used to supplement—instead of
replace—that from professionals (Bylund et al., 2007), thus forming a “triangulation” of patient–Internet–physician (Wald et al., 2007).

Prior research categorized patient–provider relationships solely based on
patient’s decision-making preferences (e.g., “You alone, mostly you, the doctor
and you equally, mostly the doctor, and the doctor alone make the decisions”; Ende
et al., 1989). This is surprising given that patient’s information-seeking and
decision-making preferences have long been recognized as tightly interconnected.
By situating these two types of patient preferences in relation to each other, the
HIW framework provides a fresh perspective in understanding patient autonomy
and patient–provider relationships. Further, by incorporating the role/potential
impact of the Internet into the analysis of patient–provider relationships, this framework enables more systematic, theory-driven examinations of the interplay between
Internet use and the transition from a provider-dependent to a more participatory
approach to health care. This framework has the potential of being extended to areas
beyond health care (e.g., information seeking and decision making in legal areas, the
relationships between the general public and lawyers).

Limitations
This study has identified four major types—but not the amount of each type—of
HIW along the dimension of decision making. Given the age range of the partici-
pants of this study and the higher percentage of Internet users among these partici-
pants (compared with their age peers), it is likely that the findings might be different
among younger age groups and among non-Internet users. Future research will
benefit from examining the types and amounts of HIW among different age groups and groups that have varying Internet experience. Such examination will help further test the generalizability of the HIW framework. In addition, the particular focus of this study on HIW determined that this study did not examine situations in which health information was deliberately avoided (Brashers, Goldsmith, & Hsieh, 2002; Miller, 1987; Schwartz, Lerman, & Miller, 1995). Future research may benefit from examining both wanted and avoided information.

Conclusion

The HIW theoretical framework developed in this study features four major types of HIW that have varying influences on decision making and implications for patient–provider relationships. This study provides evidence that the Internet has opened up new venues for information gathering and participation in decision making without changing older adults’ reliance on medical professionals. By identifying previously unmeasured types of HIW, this study validates the emerging awareness of the unique contributions of qualitative methods in medical research (Rowan & Huston, 1997). The methodological techniques used in this study can be adapted easily to reveal valuable information that often is difficult to capture by using predetermined, fixed-response quantitative methods (Kaplan, 2005).

References


