Addressing patient alcohol use:
a view from general practice

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ABSTRACT

INTRODUCTION: General practitioners (GPs) have the potential to promote alcohol harm minimisation via discussion of alcohol use with patients, but knowledge of GPs' current practice and attitudes on this matter is limited. Our aim was to assess GPs' current practice and attitudes towards discussing alcohol use with their patients.

METHODS: This qualitative study involved semi-structured, face-to-face interviews with 19 GPs by a group of medical students in primary care practices in Wellington, New Zealand.

FINDINGS: Despite agreement amongst GPs about the importance of their role in alcohol harm minimisation, alcohol was not often raised in patient consultations. GPs' usual practice included referral to drug and alcohol services and advice. GPs were also aware of national drinking guidelines and alcohol screening tools, but in practice these were rarely utilised. Key barriers to discussing alcohol use included its societal 'taboo' nature, time constraints, and perceptions of patient dishonesty.

CONCLUSION: In this study there is a fundamental mismatch between the health community's expectations of GPs to discuss alcohol with patients and the reality. Potential solutions to the most commonly identified barriers include screening outside the GP consultation, incorporating screening tools into existing software used by GPs, exploring with GPs the social stigma associated with alcohol misuse, and framing alcohol misuse as a health issue. As it is unclear if these approaches will change GP practice, there remains scope for the development and pilot testing of potential solutions identified in this research, together with an assessment of their efficacy in reducing hazardous alcohol consumption.

KEYWORDS: Primary health care; general practice; alcohol drinking; alcohol-related disorders, attitude of health personnel.

Introduction

Alcohol-related harm is a global problem. In developed countries, alcohol is responsible for 6.7% of disability-adjusted life years lost and 1.6% of deaths and is increasing.[1] In New Zealand (NZ) more than 1000 deaths every year can be attributed to alcohol, resulting in 17 000 years of life lost annually.[2] In a recent NZ study, the proportion of people drinking more alcohol over the past year had increased from 2% in 1998 to 16% in 2006.[3] The worsening of alcohol-related health problems internationally was realised as early as 1980, when a World Health Organization (WHO) expert committee on alcohol stressed the need for increased efforts to prevent alcohol-related health harms.[4] The committee called for the development of strategies that could be applied in primary health care settings with a minimum of time and resources. Primary care was identified as a key setting for the reduction of alcohol-related harm, with general practitioners (GPs) considered

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to be in an ideal position to detect, prevent and manage patients' alcohol problems.

A number of advantages of a GP-based strategy have been identified.[5] In addition to there being good evidence that brief interventions delivered by GPs have a positive impact on patients' alcohol consumption, GPs are readily accessible to the general population and have role legitimacy in the delivery of advice about alcohol consumption.[5] In most countries people with alcohol problems will first present to their GP[6] rather than to specialist treatment services.[7] It is perhaps because of this that there is a growing expectation that GPs will provide advice concerning lifestyle issues, including alcohol.[8] Evidence in support of the efficacy of brief GP interventions in this area has also been accumulating, with longer duration of counselling having little additional effect.[9]

Despite the weight of evidence in favour of brief GP-based interventions to address hazardous alcohol consumption, uptake by GPs is limited.[5] A number of challenges to introducing a discussion on alcohol in the GP consultation have been identified, including time pressure and sensitivity to the issue.[5] Consequently, GPs do not always identify patients with hazardous levels of alcohol consumption.[5,10] An Australian study[5] reported that GPs were able to identify only 28% of patients classified by the Australian Medical Association criteria as 'high risk' drinkers, while another study found that between 65% and 82% of patients with alcohol-related problems (identified by consumption levels or screening tests) were not identified by GPs.[11]

Taken together, this evidence suggests that the expectation that GP-led brief interventions could facilitate significant reductions in harm from alcohol might be somewhat optimistic. Therefore, this study assessed GPs' current practice in NZ (where GP consultation is based on a user-pays model with discounts for high needs and low income groups) and attitudes towards addressing alcohol use with their patients, together with barriers and supports to such initiatives identified by GPs.

Methods

A convenience sample of 19 GPs was interviewed by fourth-year medical students (the primary authors of the paper) while on a one-week general practice placement in Wellington, NZ. From 33 invited GPs, 14 declined (58% response rate), 11 because they were too busy, two were not interested and one was ill. GPs came from a variety of practices including privately owned and not-for-profit, central city and suburban, and a range of socioeconomic areas. This sample was similar to GPs nationally. The average age of the sample was 47 (compared to 48 nationally), the proportion of males in the sample was 56% (compared to 59% nationally), almost half (n=9) had been practising for over 15 years and the same number worked in private practice compared to not-for-profit practice (no national data available for comparison).

In addition to there being good evidence that brief interventions delivered by GPs have a positive impact on patients' alcohol consumption, GPs are readily accessible to the general population and have role legitimacy in the delivery of advice about alcohol consumption.

A semi-structured interview schedule included 15 open-ended questions covering GPs' current practice and attitudes towards discussing alcohol use with their patients and barriers to, and support needed to facilitate, such discussions. Face-to-face interviews were approximately 20 minutes long, tape-recorded with consent, and transcribed. A thematic analysis[12] was undertaken, with initial coding and analysis cross-checked by other research team members.

Ethics approval was received from the Department of Public Health Ethics Committee, University of Otago Wellington.

Findings

Current practice

Discussions with patients

The GPs in this study reported rarely discussing alcohol in their consultations. Reasons for initiating discussions with patients around alcohol included:

- suspicious clinical signs (raised by 15 GPs)
- social issues, such as domestic violence, depression or frequent work absence (mentioned by six GPs), and
- consultations with new patients (mentioned by six GPs).

Other circumstances mentioned less frequently were:

- as part of routine questioning
- in the presence of other addictions
- when the presenting complaint was related to mental health
- when alcohol was a presenting complaint, or
- when alcohol had been raised by a concerned family member.

Screening

Routine screening for alcohol misuse was not common practice in consultations conducted by these GPs. While six GPs screened all new patients for alcohol misuse, seven GPs reported rarely screening (all were from private practices and six had practised for over 15 years). Sixteen of the GPs who screened relied on a list of verbal questions (e.g. the CAGE tool—a mnemonic for attempts to reduce drinking, being annoyed when criticised about drinking, feeling guilty about drinking and using alcohol on waking),[13] three used written screening tools (the Alcohol Use Disorders Identification Test—AUDIT)[14] and, two used liver function blood tests. Of the six GPs who screened all new patients, four had practised less than 15 years and five were salaried and from not-for-profit practices (serving low income populations). All the younger GPs who screened used a routine set of questions. Fifteen of the 19 GPs were aware of NZ guidelines for alcohol screening but 13 did not use them to guide their practice.

The difficulty of raising the issue of alcohol with patients was noted by a number of GPs and some had developed tactical ways of approaching the topic, such as using the screening window (on the computer) as an excuse for asking: 'So I'll say what we're supposed to be doing is... asking everybody how much alcohol they [consume] in a week' or '[we just] need to update our details, are you allergic to anything, do you smoke or drink?' Doctors said that patients expect smoking questions so some bundle alcohol into the same question.

Interventions

GPs identified interventions including GP-delivered advice, referral to drug and alcohol services, referral to Alcoholics Anonymous, medication, and family support. Only five GPs delivered alcohol intervention to patients such as, 'counselling [during] the consultation and talking to the patient about what is a safe level of alcohol intake'. Many of these GPs found that it was sometimes very difficult to arrange follow-up visits as patients would not attend. Almost all of these GPs reiterated the importance of the patient's willingness to talk for discussion to be successful.

GP attitudes

The role of the GP

GPs in the study agreed that primary care has an important role to play in delivering primary prevention, including preventing harm from alcohol.

WHAT GAP THIS FILLS

What we already know: General practitioners (GPs) are thought to be well positioned to reduce alcohol-related harm via discussion of alcohol misuse with patients. GPs identified a number of barriers to discussing alcohol misuse as well as some potential solutions to these barriers.

What this paper adds: Although GPs in this study thought it was important to discucss alcohol use with their patients, they rarely did so unless the patient's drinking had signifant impacts on their health.

Eleven GPs felt their own advice about alcohol was useful to patients, six were undecided, and two thought it made no difference to patients' drinking. GPs expressed concern about the number of primary prevention strategies they were expected to address. Perspectives on what their role should entail varied and included: raising patient (n=7) and public awareness (n=2), referral to specialist services (n=7), providing advice (n=5), and some were unsure (n=5).

Use of screening and guidelines

Overall, GPs in the study thought that opportunistic screening was more effective than routine screening. Those who used screening questions found them 'too rigid' for the flow of consultation and therefore modified them. Reasons given for not using guidelines included constant changes being made to the recommendations, guidelines not being widely applicable, and a lack of consistency between different guidelines. One of the two GPs who used guidelines talked about the difficulty in staying up to date with the changes.

Barriers to addressing alcohol

GPs identified a number of barriers to addressing alcohol use with patients. The most common was the 'taboo' nature of the subject (n=11). As one GP explained, 'there are stigmas around [alcohol], so people don't necessarily like talking about it'. This contributes to doctor and patient discomfort. One GP noted that, 'if there is clinician discomfort about asking these [alcohol-related] questions, then they might not ask [the patient]'. Three GPs stated that they felt asking about alcohol use was 'intruding into other people's lives unnecessarily' and they feared that raising the topic could damage the doctor–patient relationship, making future encounters difficult. Another GP noted that raising the subject often made patients 'wince... and some became defensive'.

Ten GPs identified lack of time as a significant barrier. One noted that 'quality alcohol consultation should take... 15 minutes'. Perception of patient dishonesty was another commonly identified barrier. Four GPs believed that many patients were not honest about their alcohol use and therefore doubted the value of questioning patients. One stated that 'most people halve their alcohol [consumption]. We were always taught that you double what people say'. Three GPs identified that the presence of third parties, commonly family members, made it inappropriate to raise the issue. Other barriers included the patient not accepting that their drinking was a health issue, the GP feeling they did not have the expertise needed, and the GP being unable to define a safe level of alcohol consumption to the patient.

When prompted on specific patient demographics that may act as barriers, a third of GPs in the study found it difficult to raise the topic of alcohol with people of differing ethnicity and gender, and a quarter found it hard to raise with people of a different age. As one GP stated:

> ...it is always easier if you're from a [patient's] cultural group because they identify with you and it is difficult to tell someone from a very different cultural background about [alcohol]... they are less likely to listen to what you have to say.

The age barrier was a particular issue with teenage patients who see themselves as 'bulletproof', often 'don't discuss [alcohol] with older people', and often come with a parent or support person. The barriers of ethnicity, age and gender were more commonly identified by less experienced and younger GPs.

Supports identified by GPs

The majority of GPs (n=13) said that more support was needed to facilitate discussions of alcohol use with patients. Four said they did not need further support and two made no comment. Four GPs suggested this support should come from raising public awareness of the adverse health effects of alcohol. As one GP noted, 'if it's just doctors struggling with this problem it's not enough'.

Four GPs, all practising for less than 15 years, said longer consultations were needed. Four GPs suggested using standardised questionnaires, ideally administered by nurses prior to the consultation, would save time. One GP suggested that it

would be easier if a questionnaire was incorporated into a medical records computer programme.

Discussion

Routine screening of patients by GPs in this study was uncommon and alcohol use was rarely discussed with patients in their consultations. However, nearly a third of GPs screened all new patients. Slightly over a quarter of GPs delivered alcohol interventions to their patients, including GP-delivered interventions, referral and medication. This is despite evidence of the considerable potential for success.[4,5,7,9,15–17] This finding supports earlier work.[10]

While some GPs in this study were confident in this arena, most did not address the issue unless the level of drinking had led to a disease state that could not be overlooked—a finding consistent with research in this area.[18,19] Of the GPs who screened all new patients, the majority were younger and nearly all were salaried. This suggests that more recent GP training may encourage, or better equip, GPs to address alcohol issues. It may also suggest that the work context of salaried GPs is more supportive of alcohol screening than that of those who work for fee-for-service. It is possible that GPs in fee-for-service practices are under more pressure not to offend their patients in case they go elsewhere.

While GPs agreed there is an important role for primary care in primary prevention, they were less clear on what this role was in relation to alcohol. GPs were generally of the view that screening for alcohol misuse should be opportunistic rather than routine. When raising alcohol use with patients, some GPs did so following use of screening tools and alcohol guidelines, and others relied on clinical or social indicators. The study suggests that GPs find evidence-based guidelines and structured questionnaires cumbersome and if they use them they alter the validated questions.

Barriers to addressing alcohol use with patients include:

- the taboo nature of the subject
- concern about intruding into people's lives
- time shortages in consultations
- GP perception of patient dishonesty
- the presence of a third party, and
- the challenge of raising alcohol with people of different ethnicity, gender and age.

Age was a particular issue with teenagers. The majority of GPs thought more support was needed, including raising public awareness of the health effects of alcohol, longer consultations, screening prior to the consultation, and incorporation of screening tools into medical records programmes.

These findings suggest the advantages GPs have in addressing alcohol use with patients that Paton-Simpson et al.[5] identify are not widely experienced, at least by this study population. First, GPs may be accessible, but short consultations appear to be a barrier to addressing alcohol use, although evidence suggests that five minutes may be all that is required for successful intervention.[7] Further, at least in NZ, access to a GP is still limited for many. Second, many GPs in this study were not clear about the legitimacy of their role in alcohol health promotion. This may be in part because alcohol is seen as a social problem and its discussion therefore invokes social stigma rather than health issues. Third, while there is good evidence of effectiveness for GP intervention, many of the GPs in this study were unaware of, or did not believe, the evidence. The brief time required and the fact that brief interventions may be even more efficacious than specialist treatment[9] are messages that GPs need to hear. This research also confirms and extends earlier research on barriers

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to progress in this area.[10] GPs in the study provided advice about the support that would assist them.

This is a small qualitative study; hence, the findings are not generalisable. However, the sample is similar to the NZ GP population and findings are consistent with previous NZ research[10] and other research internationally.[18,19] The response rate of 58% may have introduced some bias, as most of those who declined cited time constraints. It is possible that these are the GPs most likely to spend time with patients discussing issues such as alcohol use, and that this study therefore underestimates the extent that alcohol issues are addressed in general practice. Regardless, this research suggests that a substantial number of GPs in NZ may not routinely address alcohol issues with their patients.

Conclusions

GPs in the current study rarely discussed alcohol use with their patients and most did not do so unless the level of drinking was significantly impacting on health. GPs thought that discussing alcohol use was important although they were less clear as to their role in this. These findings challenge the concept that GPs are well positioned to deliver community-based alcohol screening and brief intervention. There are unresolved societal, organisational and interpersonal barriers which deserve further exploration if GPs are to provide primary intervention to reduce alcohol-related harm.

First is the need to legitimate the role of GPs in this arena, both in the minds of the public and with GPs. A social marketing campaign that promotes the health effects of alcohol misuse and the assistance GPs can provide may encourage patients to approach their doctor, and give GPs more confidence in raising the issue without concern that they were intruding in patients' lives. Second, consideration could be given to how primary care is organised to promote alcohol health promotion, for example in terms of accessibility, funding models, time with patients, the place of screening, and screening prompts. Third, GP training should build the skills of individual clinicians including stressing the efficacy of brief intervention and building their confidence to undertake it. Addressing these issues will better equip GPs to help their patients reduce harm from alcohol misuse. Urgent action is needed if we are to stem the increasing harm from alcohol.

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AUTHOR CONTRIBUTIONS
The students (TM, JT, RP, LW, BS, PN, TP, PN, TS, MR, JR, JS, PS, PW RZ) participated in the research design, collected and analysed the data and wrote the initial report. LS, HM and GF initiated the research and supervised the researchers at all stages of the research. GJ wrote the first draft of this paper and GJ, LS, HM, GF and TM contributed to subsequent drafts and shared responsibility for editing the final version. All authors have contributed to, and approved, the final version.

COMPETING INTERESTS
None declared.

References

1. World Health Organization. Global health risks: Mortality and burden of disease attributable to selected major risks. Geneva: World Health Organization; 2009.
2. Connor J, Broad J, Jackson R, Vander Hoorn S, Rehm J. The burden of death disease and disability due to alcohol in New Zealand. ALAC Occasional Publication 23. Wellington; 2005.
3. Wilkins C, Sweetsur P. Trends in population drug use in New Zealand: Findings from national household surveying of drug use in 1998, 2001, 2003, and 2006. N Z Med J. 2008;121(1274):61–71.
4. World Health Organization. Problems related to alcohol consumption: report of a WHO expert committee. Geneva, Switzerland: World Health Organization; 1980.
5. Paton-Simpson G, McCormick R, Powell A, Adams P, Bunbury D. Problem drinking profiles of patients presenting to general practitioners: Analysis of alcohol use disorders identification test (AUDIT) scores for the Auckland area. N Z Med J. 2000;113:74-77.
6. Rush B. The use of family medical practices by patients with drinking problems. Can Med Assoc J. 1989;140:35–39.
7. Anderson P. Alcohol and primary health care. WHO regional publications. In: WHO regional publications, editor. European series No. 64: World Health Organization; 1996.
8. Wallace P, Brennan P, Haines A. Are general practitioners doing enough to promote healthy lifestyle? BMJ. 1987;297:663–68.
9. Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, et al. Effectiveness of brief alcohol interventions in primary care populations (Review). Cochrane Database Syst Rev 2007(Issue 2):Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.
10. Moriaty H, Stubbe M, Chen L, Tester R, Macdonald L, Dowell A, et al. Challenges to alcohol and other drug discussions in the general practice consultation Fam Pract. 2011. doi: 10.1093/fampra/cmr082.
11. Rydon P, Redman S, Sanson-Fisher R, Reid L. Detection of alcohol related problems in general practice. J Stud Alcohol. 1992;53:197–202.
12. Green J, Thorogood N. Qualitiative methods for health research. London: Sage; 2004.
13. Bush B. Screening for alcohol abuse using the CAGE questionnaire. Am J Med. 1987;82(2):231–35.
14. Senft R, Polen M, Freeborn D, Hollis J. Brief intervention in a primary care setting for hazardous drinkers. Am J Prev Med. 1997;13(6):464–70.
15. Bien T, Miller W, Tonigan J. Brief interventions for alcohol problems: A review. Addiction. 1993;88(3):315–36.
16. Chick J, Ritson B, Connaughton J, Stewart A. Advice versus extended treatment for alcoholism. Br J Addict. 1988;83:159–70.
17. Drummond D, Thom B, Brown C, Edwards G, Mullan M. Specialist versus general practitioner treatment of problem drinkers. Lancet. 1990;336:915–18.
18. Anderson P. Managing alcohol problems in general practice. BMJ. 1985;290:1873–5.
19. Powell A, Adams P, McCormick R. Preventive medicine in general practice with particular emphasis on early intervention for alcohol. N Z Fam Physician. 1996;23:44–7.