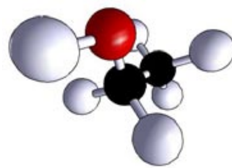
19 ALCOHOL INSIGHT



Negotiating Alcohol Problems in Primary Care Consultation: Power, Evidence and Practice

INTRODUCTION

Alcohol-related problems cause management difficulties for many GPs. It is now well established that:

- There is good research evidence that certain interventions can reduce alcohol-related problems.
- GPs believe this work is important, but often believe patients are unwilling to change their behaviour.
- A variety of social factors cause GPs to be selective about the kinds of patients they intervene with.

This study, carried out by Professor Carl May, Dr Eileen Kaner and Dr Tim Rapley from the University of Newcastle upon Tyne, aimed to identify and describe the *clinical* and *social* factors that regulate the discussion of alcohol-related problems, and how such factors promote or inhibit effective engagement with certain types of patients. Through a series of one-to-one qualitative interviews, we explored twenty-nine GPs' experiences of the detection and management of alcohol-related problems in the primary care consultation and asked them to describe, in detail, some of the consultations they have had where they have discussed alcohol with patients. We then presented the findings of these individual discussions to three task-groups containing nineteen participants. Two of these group interviews were with doctors who had taken part in the one-to-one interviews. The other group interview was with a primary care team. In the group interviews the participants discussed, challenged and enhanced our findings.

FINDINGS

- Irrespective of their knowledge of alcohol brief interventions, the vast majority of the GPs were able to describe *various elements* (though not necessarily the same) of brief interventions as a routine and normalized component of their work, but the GPs' *detection* of alcohol-related problems was variable.

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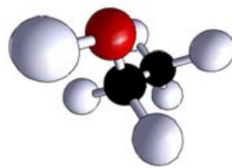

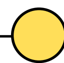

- The GPs believe that this work is important, but they feel due to their practical experience that until patients are willing to accept that their alcohol consumption is problematic they can achieve very little. They work to introduce alcohol as a potential problem, re-introduce the topic in future consultations, and then have to wait until the patient decides to change their behaviour.
- GPs' own consumption and their perceptions about the problems experienced by, or the receptiveness of, different groups of patients can result in variable engagement with alcohol issues. Patients' social class, sex and age can influence the GPs' diagnosis and intervention work. When working with specific groups of patients, like the elderly or middle class professionals, some GPs would forget to ask about alcohol or be surprised that a patient was drinking excessively.
- That a mosaic of clinical, organisational, practical and social factors cause GPs to ask questions like '*what needs to be done?*', '*what can be done?*', '*how can it be done, and when?*' in relation to each specific patient over multiple consultations.

IMPLICATIONS

- The development of future educational interventions for clinicians in primary care should be launched not solely on the basis of education, skills-building or dissemination of the current evidence-base but rather on the basis of enabling GPs to recognise the array of skills they already have and currently use when working with alcohol and alcohol related problems.
- Educational interventions need to take account of the very practical problems and dilemmas that GPs face on a day-to-day basis and seek to explore the range of solutions that the participants currently employ. They should *seek to empower GPs to recognise and enhance their current good practice*. Above all, such sessions should seek to generate a range of very practical tips, strategies and advice and should supply them with a checklist of potential courses of action to act as sources of support and reminders for their future practice.

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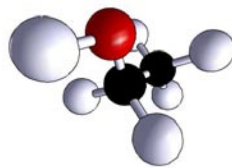

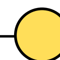

- Alcohol consumption is a behaviour that is shared by patients and GPs alike. Thus it may be difficult to maintain a professional/emotional detachment regarding this issue. Relatively little attention has been paid to exploring the role of clinicians' own drinking behaviour as a factor influencing alcohol intervention work. Selective delivery of alcohol interventions is a major challenge to overcome and a key part of this challenge is to understand and influence GPs' perceptions about which types of patients are 'appropriate' targets for intervention.
- The shift to a shared care model - where appropriate and timely 'expertise' and 'backup' is available both within and beyond practices – is central to developing successful interventions. The knowledge that practitioners are able to easily access additional layers of support and potentially refer on highly complex cases is central to encouraging them to manage people with severe alcohol problems as well as for working with binge drinking and mild alcohol problems.
- Implementation research and educational interventions needs to take account of the very practical problems and dilemmas that GPs face on a day-to-day basis. Importantly, rather than see individual GPs as *the* source of the problem and *the* target of behaviour-change interventions, researchers and educationalists need to take more account of the way that each GP is only one part of a distributed organisational, bureaucratic and social system dealing with alcohol-related problems. It is often the broader system that is a central factor that inhibits GPs' delivery of interventions.

The results of this study help to explain why some patients do not receive interventions to reduce alcohol-related problems and suggests ways to remedy this gap in service-provision so that a more consistent approach can be implemented in primary care.

FURTHER INFORMATION

Proponents of screening and alcohol brief interventions have argued that in practice, general practitioners are unwilling or unable to make use of these treatment techniques. However, in our study, in respondents' descriptions of working with patients, a maximum variation sample of GPs routinely described employing many

(though not always all and not with all patients) of the fundamental facets of alcohol brief interventions. This could be understood as another example of the 'evidence/practice gap' in health care and as a problem for implementation research and development. Such an understanding would draw out a set of recommendations about how best to translate evidence about effectiveness into practice. However, our argument is that to see the respondents' perspectives as evidence of a 'gap' between clinical evidence and everyday practice is to misunderstand the issue. Something *like* alcohol brief interventions has been *normalised* into (or has always been a part of) GPs' work and is evident in the respondents' accounts even when they rejected, or did not recognise, the particular label of brief interventions for this work. By normalisation we mean that a set of practices that seem to accord to the broad principles of brief interventions are routinely described as being embedded, locally, in clinical practice, and that it is interpreted and adapted flexibly according to the requirements of specific consultations.

All the GPs in our sample were aware that alcohol was an important factor in many consultations. They reported routinely discussing alcohol with patients with a range of alcohol-related problems – from risky drinking to severe alcohol dependence. All the GPs agreed that they were responsible for drawing patients' attention to their alcohol and alcohol-related problems. All the GPs agreed that they were well placed to do this work, that they were a key link in a network of care that included primary, secondary and tertiary care, plus various support services, self-help groups and broader public health interventions. The fact that GPs do not always intervene with every patient that presents with signs of alcohol problems does not appear to be a lack of education or skills but rather the very practical issue of case management and how they can best care for the patient that has just stepped into their consultation room. This is not to say that increased consultation times, decreased patient numbers or improved access to additional support will offer *the* solution. The problems that GPs face are found at a number of levels: within their perceptions of what constitutes alcohol-related risk, the dynamic of consultations, the relationship between other support services and primary care, and society's attitudes towards alcohol. The main challenge is to continue to support GPs to offer timely and flexible alcohol interventions. However, we also need to encourage and enable them to target these interventions to *all* those that need them, as currently, selective delivery – either due to problems of perception or other more practical factors – is still a central problem.

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