Negotiating alcohol problems in the primary care consultation: power, evidence and practice

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What we knew before

(a) There is good evidence that brief interventions can reduce alcohol-related problems in primary care, but GPs' detection and treatment of such problems is variable;

(b) GPs believe that this work is important, but that they often also believe such patients are unwilling to change their behaviour;

(c) That a variety of social factors cause GPs to be highly selective about the kinds of patients that they intervene with.

What this study has revealed

(a) That, irrespective of their knowledge of alcohol brief interventions, the great majority of GPs were able to describe *something like* brief interventions as a routine and normalized component of their work, but GPs' *detection* of alcohol-related problems is inconsistent.

(b) GPs believe that this work is important, but 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 periodically, and then wait until the patient decides to change their behaviour.

(c) GPs' *own consumption* and *their perceptions about problems experienced by, or the receptiveness of, different groups of patients* can influence their engagement in this area and result in variable intervention delivery.

(d) 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.

What we now need to know

(a) How do direct observations of actual, day-to-day, alcohol-related practice behaviour relate to the ideal-type model of alcohol brief interventions?

(b) How do interactional patterns of behaviour between GPs and different groups of patients determine if and how lifestyle behaviour is discussed during the consultation.

(c) How do different groups of patients with differing health needs and life-circumstances respond to discussion of preventive compared to curative (treatment) care.

Aims

The aim of the study was to investigate the interaction between (a) generalised knowledge about evidence-based practice in the detection and treatment of alcohol-related problems in primary care, and (b) general practitioners' (GPs) individualised constructs of the clinical and psychosocial character of patients presenting with such problems, their motivation to resolve them, and the potential for successful intervention.

We had two objectives: (i) to identify, describe and understand the tensions between 'evidence' *about* clinical practice, and practical and experiential knowledge derived *from* clinical practice; and (ii) to develop the underpinnings for a theoretical model from which the development of future educational interventions for clinicians in primary care can be launched.

Methods

This qualitative study was undertaken between 2003 and 2004, in the North-East of England. It was undertaken in two phases. In phase one we undertook semi-structured interviews, lasting between 45 and 120 minutes, with general practitioners (n=29; 15 female, 14 male) recruited according to a maximum variation sampling strategy. Variation was maximised across work pattern (19 full-time and 10 part time doctors); distribution (11 inner city locations; five suburban, four affluent suburban, four small town, and five rural practices). Variation was also maximised across professional orientation and experience, including one registrar and one newly qualified doctor; two with a special interests in substance/alcohol misuse; three police surgeons; four research active doctors; and seven who had previously been involved in prior randomised controlled trials of alcohol brief interventions. In these interviews we explored the relationships between clinical evidence and clinical practice and asked participants to review cases of specific patients with alcohol-related problems.

In phase two, we undertook three task-group interviews (May & Foxcroft 1995) with GPs and other professionals (n=19) which lasted between 70 and 90 minutes. In the group interviews we offered the preliminary results of the one-to-one interviews. Respondents then discussed, challenged and enhanced our findings. Two of these group interviews

were with doctors (n=7) who had taken part in phase one of the study. The other group interview (n=12) was with a primary care team and was made up of seven doctors, a practice nurse, a health visitor, a counsellor, and two practice managers.

The sample was not intended to provide a statistically representative sample of GPs, but rather a foundation for an intensive study of respondents' understandings of the problem and its treatment. Our study group encompassed sufficient respondent variation and permitted saturation of analytic categories. We attempted to recruit GPs who work in areas of high minority ethnic populations as well as GPs who were from minority ethnic communities, but were repeatedly unsuccessful. As such, we only have limited data on these specific topics. We also note that, as the data-collection phase started, Primary Care Trusts were implementing new legislation on research governance, our project was repeatedly delayed as these Trusts rigorously interpreted and administered these novel regulations.

Following the broad precepts of the constant comparative method (Strauss 1987) all the semi-structured and task-group interviews were audio-taped, transcribed and anonymised. Analysis was inductive (i.e. constant comparison within and between themes and deviant case analysis of outlying themes). The analysis developed until category saturation was reached (i.e. interviews and analytic procedures yielded no new material for analysis). The analysis was further developed and validated through the group interviews (contact authors for details of coding frame). In what follows, illustrative extracts from the interviews are shown with an anonymising code number for the respondent and the index line numbers from the transcript (e.g. GP2M: 38-39). Illustrative extracts from the task-groups have the additional prefix of 'TG' (e.g. TG29M: 83-86). Both sources of data have been essential in shaping the findings, but for reasons of brevity, we have mainly used illustrative extracts from the one-to-one interviews. Illustrative extracts from the task-groups will be used more fully in publications due to emerge from the work.

Results

GPs' knowledge about evidence-based practice

In all the one-to-one interviews, we specifically asked the GPs to outline what they knew about screening and brief interventions for alcohol problems and to offer concrete descriptions of what they thought this practice was. In relation to alcohol brief interventions, the types of knowledge they had was divided between three categories: no knowledge, a little knowledge and knowledge from training.

Four GPs had never heard of, read about or had training in alcohol brief interventions. Importantly, this included both the registrar and the newly qualified doctor. The majority of the GPs in our sample (n=17) had a little knowledge of brief interventions. Respondents have either heard or read about it *but were unsure about giving any technical definitions*. When they attempted definitions they outlined things like '*explaining what the safe limits of alcohol use are, some simple strategies to reduce alcohol intake*. (17M: P167-169)' and that they involved offering '*advice within a normal surgery consultation*' (23F: P147-149). Other aspects respondents identified included: discovering current levels of alcohol intake, offering appropriate advice, awareness that this was population-based strategy and positive comments on effectiveness of the intervention.

Respondents would routinely connect their descriptions to their knowledge of brief interventions for smoking. Some claimed to practice smoking brief interventions and others had been on courses about brief interventions for smoking and/or mental illness. There was also an understanding that brief interventions draw on strategies to modify behaviours. Only, five GPs discussed the evidence-base for alcohol problems in relation to the theories of stage of change model, motivational interviewing and cognitive behavioural therapy (and only one of these five GPs had been involved in a previous randomised controlled trial focused on brief alcohol intervention). Overall, when asked to describe their knowledge of the evidence-base this group offered a loose and selective version, that highlighted many, though not all, elements of an 'ideal version' of alcohol brief interventions.

Less than a third of the GPs, only four (out of seven) of those involved in a prior randomised controlled trial of alcohol screening and brief interventions, and four other GPs, had gained specific knowledge from alcohol-related training. This knowledge was derived from in-practice training sessions, CME courses and the support and advice some received whilst involved in the trial. When specifically asked to offer a definition of alcohol brief interventions, four offered a loose definition. For example, one GP explained that

> I've done a session ... picking up people at that sort of hazardous drinking end you know, who haven't got into problems and the idea of asking more people about their drinking make it more of a habit to ask people and offering sort of support around that. (AERC25F: P128)

The other four could offer more detailed descriptions. For example, one GP said she only had '*vague memories*' of being involved in a randomised controlled trial. She explained that '*what I took away from that [being involved in the trial] is it's worth asking and it's worth giving information*' (08F: 516-518). This GP went onto offer a very comprehensive description of alcohol brief interventions. This same style of practice emerged when later in the interview she discussed some encounters with specific patients.

The GPs had a broad range of 'knowledges' of evidence-based practice. Respondents' knowledge about brief interventions for alcohol was very uneven. However, whether or not they had participated in earlier research or specific training, the great majority seemed to be able to describe *something like* alcohol brief interventions as a routine and normalised component of their work. In relation to detection of alcohol problems, all the GPs were aware of the CAGE screening questionnaire. Only one third knew about alternative screening devices like the AUDIT questionnaire. Importantly, none of the GPs in our sample currently used any systematic screening devices on a regular basis, other than (infrequently) asking some or all of the questions from CAGE.

GPs' experience of the clinical and psychosocial character of patients

We asked GPs to offer estimates of the number of patients they saw with 'alcohol-related problems' in the prior month. Sixteen of the GPs were able to offer specific figures for different types of problems:

- For those patients with dependent or abusive consumption, their estimates ranged between seeing 2-3 a month to 1 a day

- For those patients with risky or excessive consumption, their estimates ranged between seeing 3-4 month to over 1 a day.

Eight of the GPs talked about alcohol problems *per se* and one described seeing '*significant numbers*' from all areas of alcohol problems. Another noted that it '*comes up opportunistically actually, maybe about once a surgery'* (2M: 38-39). Five of the GPs were either not asked or did not offer an estimate.

It was not typical for patients to directly ask for help with an alcohol problem. The GPs reported that when patient did ask they were often motivated by a crisis in their life or brought in by other members of their family. Importantly, alcohol-related risk and problems were overwhelmingly discovered through a myriad of non-specific social, psychological and pathological cues (e.g. depression, falls, obesity, relationship problems, social crisis, sleep problems, stress, tiredness) which may lead a GP to explicitly ask questions about a patients drinking habits.

Overall, alcohol-related risk and problems were overwhelmingly discovered over the course of conversation rather than through any formal screening procedure. It was most often the GP who had to decide to initiate any discussion. Screening involved simply asking patients questions like "how much do you drink", "how often do you drink", and then attempting (and this was not always easy) to work out the numbers of units. Respondents also highlighted the shift in how patients discussed alcohol

> I think there's the change, the change in perception, away from you know …"am I an alcoholic or aren't I", those kind of questions are very common a few years ago and now I think people are saying "do you think I drink too much?" which I think is a kind of more informed position (26M: 255-258)

Patients concerns and reactions were no longer solely based on conceptions of alcoholism and the social stigma that that carries. A few of the GPs gave examples of a consultation where when the subject was broached the patient reacted badly and felt they were being accused of 'being an alcoholic'. Such cases were the exceptions rather than the rule and were often tied to confronting patients who the GPs' thought were either heavy abusers of or dependent on alcohol.

Importantly, factors like social status, class and age could influence the diagnosis and possibilities of intervention. For example, when patients were embedded in a culture of excessive drinking, say university students or labourers, this established different expectations about the nature of the problem and potential for change. As students are

typically such infrequent visitors GPs may feel that an intervention may not encourage further visits and an intervention is less pressing as they are expected to 'grow out of it'. Labourers may be expected to continue to drink excessively and the hope may be to encourage a moderate decrease in consumption. Interestingly, when working with patients from specific groups, like the elderly or middle class professionals, some GPs would often forget to ask about alcohol or be surprised that the patient was drinking excessively.

> Well I shouldn't be [surprised by professionals drinking] cos I'm one and I do it (*both laugh*) I suppose but, it just it just comes as a surprise, you wonder why they do, well I suppose it's, I know why they do it don't they but er they should be able to control it better perhaps , if I can so can they , you expect them to have more nowse, more intelligence but it doesn't work , it's just the way they are , yeah … They're better at hiding it, hiding their drink problem I think (AERC13M: 554-604)

For some of the respondents, the expectation was that a professional would need less guidance whereas with a patient from a deprived area '*I wouldn't expect them to be quite so sure about what they want to do. I would expect to be able to influence them more.*' (TG07: 1247-1248).

GPs' motivation to resolve alcohol-related problems

Asking about patients' drinking was a normal practice both in relation to raising it within consultations, as new patients joined the practice and as medical records are updated. Overall, the GPs in our sample reported very few difficulties in asking patients about drinking. As one GP explained it:

> I don't feel embarrassed particularly about asking. I mean there's a lot worse things you have to ask people about, you know, than how much you're drinking. … But no, I don't find it difficult to raise usually at all. I suppose maybe that comes back to in this country it's not, to say you drink a fair amount, isn't something that's a stigma really is it. (14F: 815-826)

GPs rarely felt uncomfortable when asking about alcohol, in part, as they felt that patients expected them to ask alcohol-related questions. However, nearly all the GPs could remember one patient where they felt it was difficult to ask or that the patient reacted badly. Such experiences were the exception rather than the rule and were memorable because they were atypical.

As guidelines on recommended weekly and daily amounts of alcohol intake have been widely publicised both within primary care and to the general population, all the GPs felt

that the difference between problematic and non-problematic drinking had been clearly established.

> I think the difference now is that we are prepared to search it out, whereas in the past unless the problem was raised I expect it was largely ignored and one of the useful factors here is having to find limits as to what might and might not be normal in terms of fixed units (TG29M: 83-86)

However, the practical issues that GPs faced was not solely tied to the number of units patients were consuming. As one GP explained in relation to a specific patient '*the problem isn't the quantity she drinks, it's the reason she drinks it for*' (2F: 393-403). For the GPs, issues about establishing and making sense of the role and effect that alcohol was having on a patients' daily life, social network and health were central, over only working out the number of units patients consumed.

The GPs described working with multiple definitions of problematic drinking when trying to reach a diagnosis with a specific patient. These definitions were tied to the respondents' understandings of questions like:

- Which medical problem should take priority?
- What is a normal amount of drinking for this type of patient?
- Is this currently a problem for the patient?
- What is a healthy amount of drinking given this patient's medical problem?

Establishing the amount of units that patients drank and comparing them to the guidelines on recommended units of alcohol is one of the new ways - if not the most important way - that GPs legitimately defined an alcohol problem. However, working out the number of units to define whether this was a problem was often tempered against a range of other enquiries and practical issues. Interestingly, for some respondents, their relationship to their own alcohol consumption influenced their practice.

> I identify myself the age old teaching in general practice in alcohol - if you drink more than your doctor you drink too much - and that y'know I drink a reasonable amount, so er, I look at that and I do very consciously identify with the idea that y'know if people drink more than me than they're probably drinking too much - I don't drink anything y'know horrendously, it's probably drink to the upper limit of the accepted (GP 5M 63-78)

As another noted, '*my gold standard for myself is probably what I would consider as a gold standard for my patients*' (GP27: 983-984). So some respondents used their own alcohol consumption as a *further* source of information to help them judge whether or not a patient had a problem. As a context for this personal 'bench-marking' approach, the GPs in this study reported a range of drinking practices from abstinence, through low-

risk drinking to frequent or heavy drinking and infrequent high-intensity ('binge') drinking. No GPs reported alcohol dependence problems although one respondent described having a practice partner who was a *'reformed alcoholic'*.

The GPs were aware that they should probably identify and manage more patients than they currently worked with. As one noted, '*I mean it wouldn't surprise me to find out that actually I ought to be recognising (laughing) more than that*' (9M: 242-243). Importantly, in relation to managing risky or hazardous drinking, a lot of the GPs felt that they often only 'scratched the surface' of the number of patients who needed advice and support about risky drinking. As one GP noted, '*hazardous drinking.... probably you've never asked them, yes, I think that that's an honest answer*' (27F: 443-444). Not asking patients was often tied to competing demands.

> If I remember rightly, a couple of years ago, I went to a lecture about these brief interventions and I've forgotten her name, there was a lady who was lecturing on how doctors don't recognise it and don't do anything about it and they should be doing it and I, I suppose I felt that a bit indignant … and the point is at that time, listening to that lecture, I felt, yeah, upset, yeah, I know there's a problem, yeah I know it's there when do you want me to fit this one in? And so I haven't trained formally of brief interventions, yes I've I think it's been certain journals, BMJ, has it been in RCGP about discussing and in ten minutes looking at alcohol, yeah great I have got ten minute appointments … it would be lovely though if somebody would just have a ten minute appointment with me with one problem … you've usually got to go through three or four presenting symptoms before you get through to brief interventions. So when it comes to brief interventions it's on my radar but as being a useful tool, I've found it difficult to implement because that ten minute brief intervention has only got about a minute or two to be effectively used in the surgery. (GP29M: 438-467)

Centrally, a lack of time and working with - and having to choose between - the multiple problems the patients brought to consultations was most often cited as the main factors that stopped GPs managing more risky drinkers.

GPs' perception of their potential for successful intervention

The key factor in all consultations was getting the patient to accept that their alcohol consumption was problematic. As one GP explained it,

> I see my responsibility as getting them to see they have a problem, I think that's the battle, I've got more chance of doing anything if they can perceive they have the problem (7M: 251-254)

When tackling alcohol dependence and abuse this process was often particularly lengthy and could be drawn out over years:

> It can be like swimming through syrup and you just have to do it all with a sense of humour and sometimes over a sort of a period of time you find a window and you can start to work together (8F: 82-84).

Until the patient admitted that alcohol was a problem, respondents often felt they had achieved very little. To feel positive about working with people with severe drinking problems the GPs needed patience, needed to be aware that at some point something – generally unrelated to any action they had taken - would trigger a change and that they would have maintained a good relationship to then be able to have the opportunity to help that patient effect change.

When they worked with risky drinking, GPs routinely discussed levels of consumption that many patients still understood as 'quite normal' drinking.

> I think this is quite a hidden problem. Perhaps because it's not perceived as a problem by a lot of people and whereas other drugs are frowned upon, alcohol is certainly very much accepted in some social frameworks and it's where sort of acceptable drinking becomes problem drinking. That's the grey area and that's very difficult and I think different communities accept different levels of drinking as being normal. But I think quite often the tolerance can be remarkably high and communities' tolerance to people's drinking can be high (11F: 46-55).

Working against such perceptions – the patient's own view of their drinking as socially acceptable - and then telling them that this could lead to problems *in the future* was especially difficult when they did not *currently* suffer from any medical, social or psychological problems. As one GP noted, '*you quite often find alcohol problems that people didn't realise were problems*' (14F: 58-59). Such situations could create problems for GPs especially when patients described only drinking slightly above the recommended daily amounts. The GPs often found it hard to convince patients, without any current signs of a medical or social problem or any significant test results, that alcohol could, at some point in the future, become a problem.

Importantly, whether dealing with alcohol dependence *or* risky or binge drinking, 'hope' and 'gentle persistence' were central to a perception of the respondents' potential for successful intervention. Hope was situated in thinking that through discussing alcohol, you could stop *at least some* of the patients from continuing to drink excessively. The gentle persistence was situated in – '*repeated questioning about it, in the same way that if you keep asking people if they smoke they recognise that you think it's a hazard*' (16F: 139-141) – so that over time, through probing every now and again, they enabled the

patient to begin to think about changing their behaviour. One GP summarised the position.

> I'm not a great believer that I'm that powerful. I mean I think what you do is you offer people opportunities you offer people opportunities and you've got to have the courage to keep offering them opportunities and offering them things and they will choose to take that when it's right for them (8F: 886-899)

However, it should be noted that such a feeling of potential powerlessness is not unique to discussions of alcohol, but is a central feature in discussions of chronic disease management, and is present throughout the history of general practice (May et al. 2004). GPs often described using elements of a motivational or stages of change approach to their intervention work.

> I mean I tend to use two very general questions to start, I'll say things to people like "how do you feel about you're drinking at the minute", I'm trying to weigh up, get a general impression of whether they feel it's a problem or they get benefits from it and that sort of thing, so just getting them to try and weigh up the pros and cons really, so I'm trying to assess where they're coming from (4F: 387-393).

Centrally, such an approach is also advocated as 'best practice' by some researchers (Rollnick et al. 1992).

The shift to a shared care model - where appropriate and timely '*expertise*' and '*backup*' was available both within practices and beyond them and good communication existed - was seen as important for successful interventions. Most importantly, in the five practices that had a drugs and alcohol worker or counsellor working within or working closely with the practice, the GPs described a more positive experience. The knowledge that the respondents were able to easily access these additional layers of support was perceived as very helpful in managing people with severe alcohol problems as well as for working with binge drinking and mild alcohol problems.

Discussion

The current evidence-base shows that well defined and properly administered interventions can effect behavioural change amongst risky drinkers in general practice (Moyer et al. 2002). 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 (Adams et al. 1997, Aalto & Seppa 2001, Beich et al. 2002, McAvoy et al. 2001). However, in our study, in respondents' descriptions of working with patients, a maximum variation sample of GPs routinely described implementing many of the fundamental facets of alcohol brief interventions. We could understand this is as another example of the 'evidence/practice gap' in health care and as a problem for implementation research and development (Bensing 2000, Ghali & Sargious 2002). 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 accounted for as being embedded, locally, in clinical practice, and that it is interpreted and adapted flexibly according to the requirements of specific consultations.

It needs to be stressed that none of the GPs described currently implementing any alcohol-specific *screening tools*. So they may be undertaking a version of alcohol brief intervention but this work is *not* being undertaken consistently or in the context of a 'population screening' approach. Neither are *all* the patients that may need alcohol-related support and advice currently being recognised or receiving it. However, some GPs described that some screening work did occur in specific clinics: well-man/woman clinics, cardiovascular clinics, diabetes clinics etc.

Given the self-selecting nature of our sample – that these GPs were motivated to take part an interview – it could be argued that our sample is biased towards GPs with a special interest in working with alcohol problems. However, their reasons for taking part

ranged along a spectrum between notions of civic responsibility - an altruistic desire to help contribute to the existing knowledge irrespective of the topic - to the potential of gains derived from participation in interviews - that they may be able to learn more about other GPs' current practice or that they may be able to influence current alcohol research and policy. Finally, these were interviews in which the respondents offered retrospective (and potentially, socially-desirable) accounts of their current practice and this should not be taken as a substitute for actual observations of current practice (Strong 1980). The task group interviews, in part, offset this problem as the respondents discussed, challenged and validated the findings of the one-to-one interviews.

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 drinkers to severe alcohol dependence. All the GPs agreed that they were responsible for drawing patients' attention to their (potential) 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 distributed network of care that included primary, secondary and tertiary care, state-funded and voluntary sector groups and self-help groups and broader public health interventions. The fact that GPs do not always intervene with every patient that presents with signs of (potential) alcohol problems, which is also identified in the research literature (Lock et al. 1999, Kaner et al. 2001, Seppa et al. 2004), does not appear to be a lack of education or a lack of awareness 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 (Stange et al. 2002). As with Thom & Tellez's (1986) study, the problems GPs face are found at a number of levels:

- within the dynamics of their perceptions;
- within the dynamics of consultations;
- within the dynamics of the relationships between hospital and support services and primary care;
- within the dynamics of society's attitudes towards alcohol.

The new GP contract has created a new bureaucratic problem - the dynamics of the regulation and coordination of primary care – and that the absence of alcohol-related work as an enhanced service has the potential to place a further very practical limit on how they co-ordinate and manage their alcohol-related workload.

Although alcohol has been described as an under-recognised issue in presenting caseloads (Kaner et al. 1999), the respondents in our study outlined an enormous number and range of presenting scenarios that had led them to discuss alcohol with patients. Moreover, the complexity of the cases they described is extraordinary and often extending across months and years for patients and GPs. However, as noted above, not all the patients that potentially needed alcohol-related support and advice were currently receiving it. There were multiple reasons for this – the dynamics of perceptions, consultations, relations with support services, society and bureaucracy – as well as an individual respondents' 'blind spots' in relation to specific patient groups (for example, for some, 'the elderly', for others, 'fellow professionals') and, potentially, the respondents' relationship to their own alcohol consumption. The main challenge is to continue to support GPs to offer timely and flexible alcohol interventions and encourage them to target these mosaic interventions to *all* those that need them.

Implications

We suggest that 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*. Importantly, evidence-based alcohol practice should not to be understood as an onerous new set of tasks or a radical alternative from their current existing practice. Offering more and/or better education and stimulating greater awareness seems unlikely to produce the change that many alcohol researchers identify as necessary. 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. It should *seek to empower GPs*, to describe and discuss pragmatic and practical examples of their current practice and so seek to *encourage and enhance their current good practice*. It should also enable them to reflect on specific presenting conditions, patients, or types of consultations or patients, where they either forget or decide not to ask about alcohol problems and so encourage them to develop their own systems to attend to any selective delivery. 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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