

ORIGINAL ARTICLE

General practitioners' strategies to identify alcohol problems: A focus group study

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Abstract

Objective. To explore general practitioners' (GPs') experiences with addressing alcohol in the consultation without prior invitation from the patient. **Design and setting.** Two focus group interviews were conducted with a purposive sample of 13 Norwegian GPs in the Stavanger region. Participants were invited to talk about situations where the doctor initiated discussion of alcohol. Systematic text condensation was applied for analysis. **Results.** Participants presented a broad range of examples of what made GPs initiate discussion of alcohol, how they brought up the subject, and what happened when they did so. Sometimes they were just acting on a hunch. Family members were also occasionally prompting the doctor to act, or recent serious incidents worked as cues for asking. Routinely taking or creating an opportunity to explore was also common. Directly confronting the patient was a challenging task, and the participants disclosed experiences of how this had been achieved. **Conclusions.** Pragmatic case-finding appears to be a field of competence which can be further developed, but should be adapted to the clinical setting and the GP's personal style. It is suggested that strategies for dealing with alcohol problems in general practice should be based on a proper understanding of this specific medical context, and be adaptable to different clinical situations and the individual patient.

Key Words: Alcohol abuse, alcohol-related disorders, focus groups, general practice, preventive medicine, qualitative research

Introduction

Alcohol is a major cause of trauma, social problems, illness, and premature deaths [1,2], and there is growing concern about this in several countries [3,4]. In Norway the annual per capita alcohol consumption (>15 years) was 4–5 litres of pure alcohol for more than three decades, before a steady increase to 6.7 litres in 2009 [5].

Systematic reviews indicate that screening and brief intervention (SBI) for alcohol problems in primary care is effective, at least in male patients [6,7]. SBI implies general screening of every patient for risky and harmful drinking, subsequently offering brief interventions to patients identified [8]. When SBI is applied in general practice, however, doctors object that the required procedures are out of place, distorting the clinical interaction [9–11]. A systematic review demonstrated that the number needed to screen may be very high [8]. A recent qualitative

study on barriers to SBI for alcohol problems in general practice confirmed that doctors often experience a negative effect of screening on the doctor–patient relationship [12]. General screening is not viewed by GPs as a suitable strategy regarding alcohol problems, yet they often feel responsible and intervene when encountering alcohol-related conditions [9,12–15]. According to Nygaard et al. [14], GPs saw treatment of alcohol problems as their primary task, not prevention.

Both authors are GPs. The first author has a long-time interest in psychiatry and substance abuse. The second author has for decades performed extensive research on vulnerable issues like humiliation and shame, with a special interest in patient experiences. Our aim was to explore and describe what made the doctors initiate discussion of alcohol, how they brought up the subject, and what happened when they did so without prior invitation from the patient.

- Research has shown that GPs do not perform screening and brief interventions (SBI) for alcohol problems as recommended, but that they see identification and treatment of alcohol problems as their responsibility.
- This study gives many examples of strategies used by GPs to initiate talk about alcohol prior to the patients' invitation or consent, both routinely and on indication.
- The participants seem to pursue alcohol problems actively, with strategies adapted to the clinical setting and their personal style.
- These examples represent promising potentials for further development of strategies beyond SBI for dealing with alcohol problems in general practice.

Material and methods

Data were drawn from two focus groups with six and seven participants (Table I), and each group was interviewed once. All GPs in the Stavanger region received an invitation via the hospital's practice consultants, but most participants were recruited later on after repeated and purposive invitations to a number of doctors, selected mainly on the basis of different levels of experience and location. We conducted one session (90 minutes) with each of the groups. The first group was composed mainly of experienced doctors and the second group mainly of younger doctors, the latter also with a majority of women. A moderator (KM in the first group and TGL in the latter) called for stories about specific situations where the doctor had initiated discussion of alcohol prior to the patient's consent. The moderator asked for failures as well as successes.

The interviews were recorded on audio-files, and transcribed verbatim by TGL. Analysis was conducted as collaborative negotiations between the two

authors. We used systematic text condensation inspired by Giorgi [16,17], reading all the material initially to obtain an overall impression. Then we identified meaning units representing different aspects of the participants' experiences of initiating conversations about alcohol, and coded for these. Next, the contents of each coded group were condensed, and finally we summarized the contents of each code group to generalize descriptions and concepts concerning discussion of alcohol, how they brought up the subject, and what happened when they did so.

Results

Participants shared experiences of initiating discussion of alcohol, without prior invitation from the patient. Sometimes they were just acting on a hunch. Family members were also occasionally prompting the doctor to act, or recent serious incidents worked as cues for asking. Routinely taking or creating an opportunity to explore, for example with health certificates or when encountering new patients, was also common. Directly confronting the patient appeared to be a challenging task, and the participants disclosed experiences of how this had been achieved. These findings are elaborated below, illustrated by selected quotations with participants' names anonymized as pseudonyms.

Acting on a hunch or on a cue

Participants described a broad range of situations where the patients' behaviour made them aware of alcohol issues. The GP's concern could be prompted by patients' repeated demands for sick leave, skipping appointments, or not keeping up appearances. Several participants agreed that it was difficult to ask about alcohol consumption if they knew that the patient was having a hard time. One experienced doctor told of how she instead sometimes asked about anxiety or depression. If this was confirmed, she continued asking whether the patient was one of those who felt that a glass of wine relieved their problems. "Sliding in sideways", she called it. Some doctors stated that it was easy to forget alcohol if they just had a vague feeling that something was not right. One experienced GP said, when he responded to a story where depression and an alcohol problem had been overlooked:

I think that when I just have a feeling that there's something I can't grasp, something is missing, then that's maybe a reason to ask about alcohol. (Tony)

Table 1. Sample distribution.

Category	Variables	n
Gender	Female	8
	Male	5
Age	18–29	0
	30–39	5
	40–49	3
	50–59	4
	> 60	1
Practice type	Solo	1
	Group	12
Location	City	10
	Town	2
	Village	1

Stories about how family members prompted the doctor to confront the patient with their concern were not uncommon. The participants agreed that it was essential to be allowed by the family members to address their worries directly when talking to the patient. If not, they would not want to learn about their worries. Another experienced GP commented:

I believe, or [--] I've experienced, that when someone is complaining that their spouse is drinking, it really *is* a problem. (Gordon)

Some of the stories dealt with serious incidents regarding alcohol-related conditions. It was common to discuss hospital reports with the patients, telling them that the admission obviously was caused by excessive alcohol intake. Often the patients trivialized the incident. One GP explained that he then tried to use what he remembered from screening tools, asking the patient what others around him felt about his drinking pattern. Many of the participants said that they were quite frank with the patients. An experienced doctor stated:

One thing that prompts me to ask about alcohol consumption without the patient introducing the subject is if they've had accidents, if they've fallen at home [--]. I must admit that since I'm from [--], I don't (hesitate) to ask "Were you very drunk?". (Marie)

Routinely taking or creating an opportunity to explore

Several participants stated that they usually included alcohol in discussions about hypertension or other changes in biological parameters. This could represent a starting point for talk about potential causes of their problems, with alcohol as one option. Others employed similar strategies, emphasizing that this is quite different from declaring that the patient has an alcohol problem. A senior GP exemplified:

And then he [--] complained of his diarrhoea ... with certain symptoms I normally say "May I ask you about alcohol, how do you deal with alcohol?" ... That was clearly a positive turn of events – he was obviously relieved by having this problem addressed. (Helen)

Many participants felt a greater legitimacy when asking patients about alcohol in the context of certificates for offshore work or driving, because of the obligation to consider the needs of the community. But some of the participants contrasted this when stating that such situations could also be delicate,

because there is more at stake for the patient. One of the younger participants said:

...about certificates for offshore work and driving and such, that's not the optimal situation to ask about alcohol consumption, really. It has to be done, but you're really asking "do you have alcohol as a reason to lose your job, or do you have another reason to lose your job?" (George)

Some doctors, more often the younger ones, explained how they routinely used the electronic patient record's (EPR) section for personal data as an opportunity to ask about alcohol when seeing a new patient. The most widely used EPR in the Stavanger region includes stimulants as a paragraph in the overview section. The participants sharing this habit explained that it was much easier to ask about alcohol without any obvious reason when it was an integral part of questions about health and lifestyle. Others compared this with patient-initiated health check-ups and the initial antenatal visit. One young doctor explained:

...or you make yourself a mandate, you create a situation where taking laboratory tests comes naturally, [--] in a way build up a situation, where it's natural to address it. (George)

Confronting the patient

In addition to more or less strategic ways of asking, it was not uncommon to confront the patient more directly. One doctor reported asking bluntly "How much do you drink?" to patients wanting repeated sick leaves, and then spoke of how he once continued asking in the following consultations, although the patient denied drinking. Quite often asking directly resulted in straightforward reports of consumption. Some felt that if the relationship with the patient was good, then they could be more straightforward. A male, experienced GP said:

(I) think ...that if I'm too direct, too harsh, then they might not come back again at all. And if one beats too much around the bush and time goes by, and then years go by, them drinking more and more. (Tony)

Some of the participants, mostly the experienced ones, were concerned about young adults' alcohol consumption. They were especially concerned about young women and the risks they expose themselves to when drunk. However, they found it difficult to confront young adults with this, because of the great discrepancy between the amounts they drank and the

official recommendations, and the risk of appearing moralistic. One senior GP reported:

Then I told her "You must remember to count how much you're drinking and you should never drink more than four glasses", and the patient just laughed out loud, she found it trifling. (Helen)

Does it really matter at all?

Ambivalence on alcohol initiatives was common among the participants, and one doctor reported that she sometimes felt that things said in the consultation could be paramount, but on other days she wondered whether it would actually make a difference. But many shared the belief that dribs and drabs regarding alcohol, presented when relevant, in the long run had an effect. Several told of patients where they had suspected an alcohol problem for many years, but had never got the patient to talk about it. One participant spoke of how she sometimes asked the patient to write down their life story, and, when reporting a case where this was not successful, said:

I haven't managed to, the alcohol problem, sort of get it, but I suspect that it's there, but [I] haven't cracked the code. (Sophie)

Denial was common among patients, and sometimes very prompt. Some participants had experienced patients getting angry, but skipping follow-up was more frequent. Many worried about alienating the patient. A young, female participant explained how she was told by an elderly man that she was too young to talk to him about alcohol. The participants agreed that denial or trivializing responses from the patient made it more difficult to ask again later. A younger, female doctor said:

...when you've raised the issue and asked once it's perhaps even more difficult to raise it again ...so how do you raise [the question] the second time, then? (Irene)

A broad range of participants presented stories where their interventions had helped patients reduce drinking and improve their health and everyday life, even sometimes becoming totally abstinent. A young, male doctor told of an offshore worker in the oil industry, where excessive drinking was discovered because of a lack of normalization of liver enzymes after a septicemia. He concluded:

I really believe that he hadn't thought about this himself, he's a typical offshore worker who's sober when offshore and therefore doesn't

see it as a problem that they drink a lot when they're home. But when we've talked a little about it, he's actually realised that he had a problem with both raised liver enzymes and emerging fatty liver. But he's been back twice after that and has reduced his [alcohol] consumption considerably. (David)

Discussion

GPs involved in this study presented various strategies to reveal alcohol problems. Actions were prompted by symptoms, incidents, gut feeling, or simply routine. They did not use validated screening procedures as such, but pragmatic case finding, tuned for the clinical setting. Below, we discuss the strengths and limitations of the study design and the impact of our findings.

Sample and preconceptions

We recruited a purposive sample of local GPs, aiming for variation regarding experience, location, and gender. After the first open invitation, repeated invitations were sent to selected groups of doctors. Our sample is diverse on demographic variables, and none of the participants hold positions in units working specifically with substance abuse. GPs in the area were invited individually, thus avoiding the problem of established group dynamics. Apart from a majority of participants practising in cities, the participants do not differ systematically from Norwegian GPs as a group [18].

We aimed for exploration of strategies used in general practice, but not for prevalence or the complete range of potential strategies. The participants' stories represent their recollections of what prompted them to enquire about alcohol, how they did it and what happened, as well as their reflections on both their own and other participants' actions.

Our preconception, based on earlier research [13–14,19–20], was that although GPs feel responsible for identification and treatment of alcohol problems, they rarely use validated SBI procedures. In the interviews we therefore asked specifically for experiences of initiating discussion of alcohol prior to the patient's consent. The participants presented a variety of examples of what prompted the intervention and how they performed it.

We planned for two groups, with the option of arranging a third group. According to a recent review of the literature [21], two to five groups is a common recommendation. The research literature and textbooks diverge when it comes to recommendations for sample size in focus-group interviews. Most authors

point out that there is no magic number. The important question is whether the research question is adequately answered [18,22–23].

After conducting the two first groups, we critically read through the transcripts and found the material abundant in relevant events, sufficient for analysis. Analysis demonstrated a broad range of findings, the second group primarily elaborating on the findings from the first group. The material from the two groups consists of many different events and experiences where the doctor, because of situation-specific or patient-specific factors, decided to address alcohol without prior invitation from the patient. We concluded that the data were sufficiently saturated, enabling an exploration of GPs' experiences of initiating talks about alcohol.

Pragmatic case-finding – an underestimated strategy?

Analysis supported earlier findings that GPs see the identification and treatment of alcohol problems as their responsibility, and furthermore that they do not see general screening as a suitable strategy for this purpose [13–14,24]. None of the participants reported using formal screening procedures, but several gave examples of informal screening strategies. Some doctors, and more commonly younger ones, were routinely asking about alcohol consumption when encountering a new patient. It was also common to screen patients attending for certificates or licences.

As in previous research [9,13,15,24], participants in our study were alert when encountering incidents or clinical problems highly indicative of alcohol problems. More importantly, they were also often alert in situations that were more vague, where the link between symptom or situation and alcohol consumption is far from obvious. They demonstrated awareness of many different patient and situational factors suggesting when it is appropriate to address alcohol – an awareness we think is crucial [25].

Our study adds to previous knowledge by exploring how GPs adapt different strategies for case-finding to the clinical setting and their personal style. This pragmatic case finding might be a powerful tool in general practice, and warrants further study and development. Landstrom et al. describe the transition of deliberate, favourable strategies into personal style as a key aspect of professional development [26], and the participants in our study give examples of this. Although our sample is restricted, the stories presented suggest that GPs are actively pursuing alcohol problems, and that they are using a range of different strategies [12,14].

There are, however, ethical considerations concerning lifestyle interventions in general practice. The clinical encounter entails inherent risks for humiliation

or disempowerment, as the problem at hand is often defined by the helper instead of the patient [27–29]. Many participants in our study pursued the issue, even after the patient denied any alcohol problem. They were ambivalent, focusing both on the risk of alienation, and on the risk of worsened health if they backed off. They were very concerned about the missed opportunities, and many shared the feeling that there were both patients they did not manage to identify, and patients identified who declined any help. At the same time they were aware of the dilemma of how to address alcohol in ways that actually might help the patient to gain better health.

GPs try to preserve the patient's dignity while intervening towards lifestyle problems, but also sometimes intentionally trigger feelings of guilt and shame to promote change [30]. Imposing negative feelings to promote change is an ethically problematic strategy, and probably not as effective as more autonomy-supportive strategies [31]. Another recent study suggests a framework for developing more patient-centred strategies, incorporating the different aspects of the patient's life world [29]. Patients with weight problems want their doctor to address their obesity, but in a respectful manner [32,33]. Weight problems and alcohol problems are sensitive lifestyle issues, as they both signify a loss of control. We suggest that sensitive issues should be handled with great consideration in order to remain within a patient-centred framework, where empowerment can be promoted [27].

Implications

Our study demonstrates the potential for development of better adapted strategies for dealing with alcohol problems in general practice than SBI. Our findings suggest that strategies further elaborated from this experiential knowledge might improve GPs' identification of as well as methods of dealing with alcohol-related health problems. Such strategies should be based on a proper understanding of GPs' working styles, and aimed at offering varied approaches to the specific clinical situation and the individual patient. The pragmatic case-finding we have presented gives examples of strategies well suited for general practice, and warrants further studies and development.

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Ethical approval

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Declaration of interest

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

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