Heavy drinkers' expectations and experiences when discussing alcohol use during a general practice visit in Australia: A qualitative study

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Background and objective
Our understanding of community members' expectations and experiences of discussing alcohol use in general practice settings is limited, particularly for people with heavy alcohol use.

Methods
Qualitative interviews were conducted with people with heavy alcohol use to explore their experiences of discussing alcohol use with their general practitioner (GP). Interviews were audio-recorded and transcribed, and data were analysed using an inductive thematic approach.

Results
Three themes were identified: (1) patient perceptions of alcohol discussions in primary care; (2) the importance of the doctor–patient relationship; and (3) consequences of unmet health needs and expectations. Patients expect their GPs to initiate conversations about alcohol use. Positive interactions are characterised by GPs' caring, non-judgemental and collaborative approach, whereas negative interactions focus on a perceived lack of knowledge or ability to manage excessive alcohol use.

Discussion
Alcohol harm reduction efforts should include strategies for bolstering the therapeutic relationship between GPs and their patients.

ALCOHOL-RELATED HARM is a major international public health concern. Harmful alcohol use contributes to three million deaths and the loss of 132.6 million disability-adjusted life years annually.[1] Although the overall rates of alcohol consumption were falling in Australia, there has been an uptick since the COVID-19 pandemic,[2] and the rate remains higher than in similarly developed countries.[3] Recent estimates suggest that up to 25% of Australian adults consume alcohol at excessive levels, defined as having more than two standard drinks per day on average (lifetime risk) or more than four drinks on any one occasion (single occasion risk).[4] Included in this figure are the estimated 4.1% of people who consume alcohol at levels consistent with alcohol dependence or alcohol use disorder.[5]

General practice is a key provider of medical care for people who are consuming alcohol at excessive levels and a gateway to medical and social support services. Most Australians (85%) see their general practitioner (GP) at least once a year. Current best practice evidence supports GPs and practice nurses routinely assessing alcohol use and offering treatment to reduce alcohol-related harm.[6] This might include an alcohol brief intervention, where patients are counselled on the risks to their health from harmful alcohol use and are encouraged to reduce their alcohol use, or referral to a comprehensive alcohol and other drugs treatment program.

Although discussing alcohol use in consultation is strongly encouraged, research suggests that it is not routinely done.[7] Although barriers to discussions about alcohol are well documented from a practitioner perspective,[8,9] there is limited consideration of patients' expectations and experiences of such conversations within the Australian primary care context.[10] This is particularly true for patients with heavy alcohol use and dependence issues.

Our aim is to describe the expectations and experiences of community-dwelling patients when talking with their GP about alcohol. We are particularly interested in patients with a prior history of high levels of alcohol use.

Methods

The study applied a descriptive qualitative approach to interviews of healthcare consumers with experience discussing alcohol in general practice settings from across Australia.

Sampling strategy

Participants were recruited through advertisements on an online marketplace, the social media page of a healthcare consumer network and a peer support group for people wanting to reduce their alcohol use. Participants needed to be over the age of 18 years, able to converse in English and able to provide informed consent. Participants were offered an honorarium of $20 for their time. Recruitment and data collection ceased when the research team determined that saturation was achieved.

Researcher characteristics

An interview guide was developed by a primary care clinician (ES) and a research officer (NG) with input from a research team with expertise in primary care (CT, LB, CB, DM and GR), alcohol and other drug research including addiction (TL, SN and DJ) and implementation science (RO and HS). The interview guide is provided in Appendix 1 (available online only). Two researchers with experience in qualitative methods conducted interviews (NG and NW). Interview guides were adapted based on emerging findings in consultation with the team.

Ethical considerations

The Monash University Human Research Ethics Committee granted ethical approval for this study (reference 21346). Participants were advised about resources available to support them should they experience research-related distress prior to data collection.

Data collection methods, processing and analysis

Qualitative data collection was guided by a semi-structured interview guide. All interviews were audio-recorded. De-identified audio files were transcribed verbatim by a professional transcription service. Transcripts were imported into the NVivo software program (Lumivero, Denver, CO, USA). Two researchers (CT and KN) carried out inductive thematic analysis. The analysis team (LS, NG, CT and KN) met regularly to discuss and interpret emerging findings.

Results

Participant characteristics

A total of 17 participants were recruited to the study. Researchers recruited two participants through the online marketplace. The remaining 15 participants were recruited from the healthcare consumer network through their social media page and links to an alcohol peer support group. Researchers were not involved in recruitment activities due to ethical issues with accessing identifiable data so were unable to distinguish between participants recruited through the latter two methods.

Participants were mostly female (10, 58.8%), aged between 45 and 64 years (10, 58.8%) without any indications of socioeconomic disadvantage (15, 88.2%) and had a current or past history of risky alcohol use (15, 88.2%). Some had recently become abstinent in their alcohol use (10, 58.8%) (Table 1).

Synthesis and interpretation

Patient perceptions of alcohol discussions in primary care

When interviewed about their thoughts on the role of GPs in alcohol enquiry, participants had an expectation that alcohol enquiry would occur and described contexts in which it would be expected and appropriate. Although many participants expected their GPs to initiate the discussion, they mentioned that it was not expected unless the patient had an active disease or diagnosis that might be affected by alcohol consumption:

> *It only depends if you're at risk ... I don't think it's particularly relevant if you're not suffering from any serious disease ... It doesn't seem relevant to me ... They only ask if you have like a liver condition.* (P1)

Participants did identify specific situations where they considered alcohol enquiry to be appropriate, such as when alcohol was seen to relate to their presenting complaint, the reason for their consultation (eg blood test results) or past medical issues:

> *If it's relevant to some kind of issue that I've got ... If I thought it was relevant to the reason I've gone in there, I'd be quite happy ... I wouldn't find it too confronting.* (P16)

> *If they see that it could be a contributing factor to poor health ... I can't imagine they'd ask a question out of the blue.* (P4)

Alcohol enquiry might be less confronting when asked in a series of lifestyle questions,

Table 1. Demographic and alcohol use characteristics of participants

Participant number	Age (years)	Gender	Low socioeconomic status indicators	Assessment of current alcohol use based on AUDIT-C responses
1	25–34	Female	None	Abstinent
2	18–24	Female	None	Abstinent
3	45–54	Male	None	Abstinent
4	65–74	Female	None	Risky drinker
5	25–34	Female	Health Care Card holder	Risky drinker
6	35–44	Female	None	Abstinent
7	65–74	Female	Receives government pension	Abstinent
8	45–54	Female	None	Abstinent
9	55–64	Male	None	Abstinent
10	45–54	Female	None	Abstinent
11	55–64	Male	None	Risky drinker
12	55–64	Female	None	Abstinent
13	45–54	Female	None	Risky drinker
14	55–64	Male	None	Low risk
15	55–64	Male	None	Abstinent
16	45–54	Male	None	Risky drinker
17	25–34	Male	None	Low risk

AUDIT-C, modified Alcohol Use Disorders Identification Test, comprising three items from the original 10-item tool.

such as alongside diet, exercise and smoking, particularly in the context of a standard routine:

> *She was just asking the standard exploratory question bank … It wasn't because she had any assumptions about me.* (P5)

> *It's like putting my car in for service. It's … you know, they do the, the 12-point check.* (P11)

There were a range of beliefs regarding the situations in which alcohol discussions were relevant and acceptable. Notably, one participant remarked that relevance was limited to only severe alcohol use problems or when initiated by the patient themselves:

> (It is) *important for GPs to have those conversations in relevant contexts so if there's reason to suspect that somebody is drinking a lot, or if it comes up from the patient.* (P17)

This link between the perceived relevance of alcohol discussions and the severity of alcohol use problems might contribute to the assumption held by patients that GP-initiated enquiry implies a judgement that they have a problem with drinking, something that is experienced as confronting and potentially offensive. Constructing a shared alternative narrative so that alcohol discussions are perceived as generally relevant might be an important strategy for clinicians to use. Having a varied and adaptive approach that accounts for the individual health beliefs of the patient is important.

Importance of the patient–doctor relationship

When interviewed about their own experience of alcohol enquiry with their GPs, participants expressed a variety of positive and negative experiences.

Those who spoke favourably about their experience described GPs who were caring, non-judgemental and collaborative. Discussions about alcohol might be shameful or anxiety-provoking for the patients, or they might have expectations that it could be. Participants preferred doctors who were perceived as being able to listen and hold onto patients' stories and their distress:

> *Her* (the doctor's) *reactions were what I was hoping for, that there wasn't going to be judgment, and there wasn't going to be surprise, but it was rather, 'Okay, what can we do here?'* (P3)

> *She would certainly offer suggestions … in a very supportive way and not necessarily anything that really helped, but it just helped in that she listened.* (P8)

Participants spoke warmly of GPs who shared decision making and worked with them in the alcohol discussion:

> *She listened, and together we mapped a plan forward.* (P3)

These experiences were well received by participants as they felt understood and had confidence in these GPs. This confidence arose from their good relationship with clinicians. Good patient–doctor relationships were described in terms of clinician kindness and mutual respect:

> *It's … it was about the human relationship. The human element. The, 'Hey, I'm- I'm in … I think I'm in crisis here. I need help'. And reaching out and not being … not being chastised.* (P3)

Compatibility of personal values or personality enhanced the patient–doctor relationship:

> *I'm drawn to his philosophy of life … If I don't, if I don't gel with and click with them or I value their, their ethics, I don't wanna even talk to them.* (P4)

Participants who spoke negatively about their experience described GPs who were embarrassed, awkward and uncomfortable. They described feeling dismissed or rejected:

> *I can remember at the time thinking … they had very little, um, um, tolerance almost for me. Um, it was almost as though it was, I was an imposition.* (P12)

Consequences of unmet needs and expectations

Most participants in our sample reported experiencing negative interactions with GPs surrounding alcohol discussions. This seemed to result in participants concluding that the role of GPs in this area was quite limited or should be diminished:

> *I don't think that a GP is the solution. I see GPs as a conduit. I don't think that we should be expecting GPs to resolve people's alcohol abuse issues … They might act as a gateway for a referral, um, I'm not quite sure what to, like, let's say if I wanted to access an alcohol service. I'm not sure what the referral procedures there are.* (P17)

> *Someone that may be more skilled in counselling or psychology … may be needed.* (P3)

Some participants seemed to indicate that there might not be a role for GPs at all:

> *So I'll have to go through a GP or if I could do it, if I could bypass them.* (P17)

Participants who were disappointed with their prior interactions with GPs felt that this was because GPs lacked knowledge or ability around managing alcohol problems:

> *They were quite puzzled, and they actually weren't too sure how to go about it.* (P12)

> *This is probably something they don't know enough about.* (P7)

This might explain the preponderance of suggestions that involved knowledge-based interventions in general practice, such as apps, websites, posters, surveys and toolkits:

> *If the GPs could have as many resources as possible to offer to patients, then I think that would be really beneficial.* (P8)

However, participants who had positive experiences did not attribute their experience to GPs' knowledge. Instead, they spoke about a 'human connection' formed between the GP and the participant as the basis for their positive experience. Participants most valued the feeling of being cared for and supported through their alcohol use problems. Being part of a therapeutic patient–doctor relationship might be seen as the required context that enables alcohol interventions to work in general practice settings:

> *Not being chastised, but rather, 'Okay, let's work on this together'. And that, that was very powerful for me.* (P7)

Discussion

Our work offers insights into how the expectations and experiences of patients who consume large amounts of alcohol can influence alcohol-related conversations in general practice. The three themes that emerged are discussed in detail below.

First, we considered patients' perceptions around the relevance of alcohol-related discussions within a general practice setting. Our finding that patients who had experienced alcohol-related harms thought that alcohol-related discussions were relevant and even expected their GP to initiate them is well aligned with existing literature.[11–13] We found that some patients might consider these discussions unwelcome,[14] particularly if they presented with conditions that they perceived as unrelated to alcohol use. Patient perceptions of the acceptability of alcohol enquiry by GPs can vary substantially depending on the reason for presentation.[15] It is important for GPs and other primary care providers to construct a narrative that supports their enquiry into a patient's alcohol use, for instance, explicitly linking the assessment to the reason for presenting or using a preventive health assessment framework such as the *Smoking, nutrition, alcohol, physical activity* (*SNAP*) guidelines.[15,16,17] Patients' established social and cultural expectations of alcohol vary, potentially substantially. Alcohol use problems are historically stigmatised, and these social values are inescapably part of the patient–doctor relationship in primary care.[18,19] This magnifies the likelihood of discussions around alcohol being experienced as morally charged – both in practice and expected/projected. In essence, alcohol use discussions can be seen as 'difficult conversations', with the potential for strong negative emotions such as shame to be elicited.[20] Given the importance of the patient–doctor relationship as expressed by the participants, this work is something that needs to be done expertly and with care.[21]

Second, we explored patients' perceptions of the doctor–patient relationship during alcohol-related discussions. Positive consultation styles were characterised as being genuine, collaborative and non-judgemental. In contrast, negative experiences occurred when the GP appeared embarrassed, awkward or uncomfortable when discussing alcohol-related harms with their patients. Negative experiences also occurred when patients felt chastised for their alcohol use or had their concerns dismissed. Patients interpreted their negative experiences as indicative of the GP's lack of knowledge or ability, which complements existing evidence that positive consultations reinforce patients' trust and confidence in GPs as appropriately skilled and knowledgeable in alcohol harm reduction.[11] Our research shows that positive consultation styles are powerful for engaging patients in alcohol harm reduction discussions.[21] The enduring therapeutic relationship over time needs to be seen as an enabling context for the implementation of specific resources and interventions.[22,23]

Finally, we found that patients who had negative experiences when attempting to discuss their alcohol use with their GP felt that GPs in general were not equipped to address alcohol-related harms in the community. Some felt that GPs could act as gatekeepers and direct patients to alcohol harm reduction services. These impressions can be interpreted through the lens of unmet expectations.[6] Patients who had expected support from their GP but then had a negative experience might react by minimising the role of GPs in alcohol harm reduction in more general terms.

Our work has several implications for clinical practice. We show that difficult conversations around alcohol use can be made more acceptable to patients when GPs use positive consultation styles within the context of a strong therapeutic relationship. This highlights the need for system supports and reforms for GPs to optimally deliver effective alcohol brief interventions in a person-centred way or at the very least not be penalised from a remuneration perspective for taking the time needed to have difficult conversations. We also show that a single negative experience can prevent patients from seeking help for their alcohol use. It would be helpful for these patients to have multiple pathways for accessing alcohol and other drug services, including self-referral, so the health harms of their alcohol use can be addressed.

Strengths and limitations

Our team included experienced GPs with clinical and research interests in alcohol harm reduction. Their input into research methods and interpretation is a strength of this work.

Our sample comprised people who had severe alcohol use problems and did not include people with indications of socioeconomic disadvantage. Our findings might be less applicable to those with moderate alcohol use problems and to disadvantaged groups. However, the findings of this qualitative study are largely concordant with prior research in patients recruited from general practice; therefore, the core insights from the findings could be broadly transferable in the contemporary Australia primary care setting.

People with more severe alcohol use problems are more likely to have negative or disappointing experiences when attempting to seek help for their alcohol use. This can lead to negative perceptions about the role of general practice in alcohol harm reduction efforts. Efforts to promote alcohol discussions in general practice should consider strategies for strengthening therapeutic relationships between the GP and their patients, in addition to improving knowledge of alcohol-specific resources and interventions.

Further research is needed into the experiences of disadvantaged groups and those with moderate alcohol use problems.

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