How Primary Care Providers Talk to Patients About Alcohol
A Qualitative Study

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BACKGROUND: Alcohol misuse is a common and well-documented source of morbidity and mortality. Brief primary care alcohol counseling has been shown to benefit patients with alcohol misuse.

OBJECTIVE: To describe alcohol-related discussions between primary care providers and patients who screened positive for alcohol misuse.

DESIGN: An exploratory, qualitative analysis of audiotaped primary care visits containing discussions of alcohol use.

PARTICIPANTS: Participants were 29 male outpatients at a Veterans Affairs (VA) General Internal Medicine Clinic who screened positive for alcohol misuse and their 14 primary care providers, all of whom were participating in a larger quality improvement trial.

MEASUREMENTS: Audiotaped visits with any alcohol-related discussion were transcribed and coded using grounded theory and conversation analysis, both qualitative research techniques.

RESULTS: Three themes were identified: (1) patients disclosed information regarding their alcohol use, but providers often did not explore these disclosures; (2) advice about alcohol use was typically vague and/or tentative in contrast to smoking-related advice, which was more common and usually more clear and firm; and (3) discomfort on the part of the provider was evident during alcohol-related discussions.

LIMITATIONS: Generalizability of findings from this single-site VA study is unknown.

CONCLUSION: Findings from this single site study suggest that provider discomfort and avoidance are important barriers to evidence-based brief alcohol counseling. Further investigation into current alcohol counseling practices is needed to determine whether these patterns extend to other primary care settings, and to inform future educational efforts.

KEY WORDS: alcohol drinking; primary care; communication; physician-patient relations.

METHOIDS

This single-site study was designed as a companion to the multisite Ambulatory Care Quality Improvement Project (ACQUIP). The ACQUIP trial used mailed surveys to identify patients with 6 conditions, including alcohol misuse, and evaluated whether giving providers information about their patients’ self-reported health status before each visit improved patient satisfaction and health status. The Ambulatory Care Quality Improvement Project was conducted at 7 VA General Internal Medicine (GIM) clinics, and all GIM patients with a visit in the past year were eligible. At each site, GIM providers were assigned to either the Intervention or Usual Care arm, with Intervention providers receiving feedback about their utilization in patients who drink above recommended limits, the U.S. Preventive Services Task Force recommends routine alcohol screening, followed by brief counseling with patients who screen positive. Effective brief alcohol counseling is typically patient-centered and includes expression of concern, feedback linking the patient’s drinking and health, explicit advice to reduce drinking, and agreement on a patient-oriented plan.

Providers generally believe that addressing alcohol misuse is an important clinical responsibility. However, rates of alcohol counseling are low, ambitious efforts to implement primary care alcohol counseling have not succeeded, and providers report a number of barriers to having alcohol-related discussions. Such barriers include confusion as to what constitutes alcohol misuse, fear that asking about drinking could harm the patient-provider relationship, stigmatization of substance abuse, skepticism about the effectiveness of alcohol counseling, lack of time, inadequate training, and a belief that patients will not honestly disclose their drinking practices. Little is known, however, about how providers actually talk to patients about alcohol use, as most studies have relied on patient or provider self-report.

The purpose of this exploratory study was to describe audiotaped alcohol-related discussions between patients who screened positive for alcohol misuse and their primary care providers. Using a qualitative approach, we sought to identify major themes that emerged during discussions of alcohol use in a primary care setting.
patients' health status. The ACQUIP intervention had no significant beneficial effect. 29

Data Collection

Audiotapes for the present study were collected at 1 ACQUIP site. Providers were invited to participate in a study of patient-provider communication by an investigator whose research does not relate to alcohol. All GIM providers at the study site were eligible, except 4, who were involved with design or institutional approval of this audiotape study (n=84 eligible).

Patients of consenting providers were eligible if they screened positive for alcohol misuse on the baseline ACQUIP survey and indicated on a separate mailed form that they would be willing to consider participating in an audiotape study of patient-provider communication. Patients screened positive if they reported any alcohol use in the past year and reported drinking above recommended limits (≥14 drinks per week or 5 or more drinks per occasion), scored ≥1 point on the CAGE questionnaire (standard timeframe of "ever"), or reported ever having had a drinking problem. This validated screening strategy has 92% sensitivity and 50% specificity for the detection of alcohol misuse in a male, VA primary care population, and a similar strategy has been used previously in trials of brief alcohol counseling. A cut-point ≥1 was used because the standard CAGE cut-point (≥2) has low sensitivity (53%) for alcohol misuse in this population. Of 7,700 patients from the study clinic who were eligible for ACQUIP, 4,046 (52%) returned the baseline survey before the start of the audiotape study, and 840 (21%) screened positive for alcohol misuse. Of those, 279 indicated that they were willing to consider participating in an audiotape study of patient-provider communication, and 130 had a consenting provider. Female patients were not audiotaped because of inadequate numbers.

Before the first visit between eligible patient-provider pairs, a research assistant (RA) obtained written informed consent from the patient, including explicit consent to allow review of the audiotapes by unnamed investigators. For this subgroup of visits, the RA placed a tape recorder in the provider's room and retrieved the audiotape after each appointment. The audiotapes were transcribed with identifying details deleted.

The previously published quantitative analysis of these audiotapes described the frequency of prespecified patient and provider behaviors during the alcohol-related discussions. During coding for the previous study, investigators noted qualitative aspects of patient-provider interactions not captured by the quantitative coding system. Two investigators with expertise in qualitative research methodology and 2 new coders were recruited to conduct qualitative analyses. The study was approved by the local institutional review board.

At the end of the study, patients and providers completed a survey, which evaluated whether they believed that the study was focused on any of 9 conditions, including alcohol misuse. No participant believed that alcohol misuse was the study's sole focus.

Among eligible patients with a consenting provider (n=130), 98 had 1 or more appointments during the 6-month study period, 53 consented, and 47 were audiotaped at least once (Fig. 1). Of 68 visits recorded, 39 contained some reference to alcohol and were included in analyses presented here.

Coding and Analytic Methods

Two authors (K.M., N.C.) independently listened to and coded the 39 visits in their entirety. Coders did not discern systematic, qualitative differences between Intervention and Usual Care providers or between types of providers, so audiotapes were analyzed as a single data set.

A descriptive thematic analysis of the audiotapes, an approach based on grounded theory, was used. In particular, attention was paid to the sequence of, timing, and responses to verbal statements. The 2 coders performed open-coding of all 39 tapes, identifying patient and provider behaviors as they emerged from the data. The lead author grouped excerpts illustrating these behaviors into categories, with some excerpts falling under multiple categories, and then organized the categories into broader thematic groups. Categories were intended to be neutral and purely descriptive—for instance, "Provider changes subject" and "Patient initiates alcohol discussion." To maximize trustworthiness (a concept comparable to internal validity for quantitative studies), all authors reviewed and critiqued 3 interim versions of the themes, proposing alternative interpretations and asking for further supporting observations for each theme. This iterative process resulted in progressive refinement of the themes.

To illustrate each theme, 3 to 4 examples were chosen based on their clarity and interpretability from a brief excerpt.

RESULTS

Study Population

Of 84 eligible providers, 34 (40%) consented to participate, and 17 had a visit with an eligible patient during the study period and were audiotaped. Taped providers were more likely than nontaped providers to be staff physicians (65% vs 35%, P=.026), but no gender differences were found. Of the 14 providers who discussed alcohol use with 1 or more patients (Table 1), 5 practiced in the ACQUIP intervention firm and received reports about their patients' drinking.

Of 47 taped patients, 29 discussed alcohol use with their provider (Table 1) in a total of 39 visits. Taped patients had a mean age of 61, and a higher incidence of chronic obstructive pulmonary disease compared with nontaped patients (n=793) (38% vs 25%, P=.05). Twenty-seven patients reported past-year binge drinking and 17 screened positive on the standard CAGE.

Themes

Three themes emerged from the 39 visits in which alcohol was discussed. Alcohol-related discussions lasted from 2 seconds to 7 minutes, 17 seconds (median duration 45 seconds; interquartile range 26 seconds to 2 minutes, 40 seconds).

Patients Disclosed Information Regarding Their Alcohol Use, But Providers Often Did Not Explore These Disclosures. We observed many instances of patients' disclosing potentially important information regarding their drinking, both in response to provider's questioning and without any prompting. Specifically, patients disclosed high levels of consumption and negative health consequences. Providers, however, often failed to pursue these disclosures.

Providers responded to patient disclosures in several ways. Some abruptly changed the subject (Table 2; Examples 1, 2, 3),