Alcohol-related Discussions during General Medicine Appointments of Male VA Patients Who Screen Positive for At-risk Drinking


OBJECTIVE: This study describes primary care discussions with patients who screened positive for at-risk drinking. In addition, discussions about alcohol use from 2 clinic firms, one with a provider-prompting intervention, are compared.

DESIGN: Cross-sectional analyses of audiotaped appointments collected over 6 months.

PARTICIPANTS AND SETTING: Male patients in a VA general medicine clinic were eligible if they screened positive for at-risk drinking and had a general medicine appointment with a consenting provider during the study period. Participating patients (N = 47) and providers (N = 17) were enrolled in 1 of 2 firms in the clinic (Intervention or Control) and were blinded to the study focus.

INTERVENTION: Intervention providers received patient-specific results of positive alcohol-screening tests at each visit.

MEASURES AND MAIN RESULTS: Of 68 visits taped, 39 (57.4%) included any mention of alcohol. Patient and provider utterances during discussions about alcohol use were coded using Motivational Interviewing Skills Codes. Providers contributed 58% of utterances during alcohol-related discussions with most coded as questions (24%), information giving (23%), or facilitation (34%). Advice, reflective listening, and supportive or affirming statements occurred infrequently (5%, 3%, and 5%, of provider utterances respectively). Providers offered alcohol-related advice during 21% of visits.

Sixteen percent of patient utterances reflected “resistance” to change and 12% reflected readiness to change. On average, Intervention providers were more likely to discuss alcohol use than Control providers (82.4% vs 39.6% of visits; P = .026).

CONCLUSIONS: During discussions about alcohol, general medicine providers asked questions and offered information, but usually did not give explicit alcohol-related advice. Discussions about alcohol occurred more often when providers were prompted.

KEY WORDS: alcohol; primary care; brief interventions; motivational interviewing.


Over 21 million U.S. adults suffer from alcohol abuse or dependence, and many others drink at levels known to increase their risk for adverse psychosocial, legal, and health consequences. Each year, many of these patients see health care providers, but less than 20% report having received advice to change their drinking. A number of randomized controlled trials of brief primary care interventions with at-risk drinkers have demonstrated decreased alcohol consumption after brief counseling or advice. Although the exact intervention studied in each trial has varied, most trials taught providers to engage in empathetic, nonconfrontational, patient-centered discussions. Such discussions included assessment of the patient’s drinking, alcohol-related problems, and readiness to change drinking, as well as feedback to patients on the relationship between their drinking and health. Explicit advice for patients to drink moderately or abstain has been included in most brief interventions found to be effective in randomized controlled trials.

On the basis of these brief intervention trials and meta-analyses of their findings, leading academic and scientific review groups have urged clinicians to routinely screen all primary care patients for at-risk drinking and counsel those patients who screen positive. However, the actual effect of alcohol-screening programs on alcohol-related discussions during primary care appointments is not known. Exit interviews with patients, and reports
by physicians,18 have been used to study alcohol-related discussions with primary care patients who screen positive for at-risk drinking, but no published study has directly observed or recorded primary care encounters with these patients.

We conducted a 6-month study evaluating the feasibility of audiotaping clinic visits of general medicine patients who screened positive for at-risk drinking. The study clinic included 2 firms, one of which had been randomly selected to receive a provider-prompting intervention as part of the Ambulatory Care Quality Improvement Project (ACQUIP) study. This report describes audiotaped discussions about alcohol use and compares rates of alcohol-related discussions in the Intervention and Control firms. We specifically sought to evaluate whether providers were including key components of brief interventions (e.g., feedback and advice) and if the style of these discussions was patient-centered.

METHODS

Setting and Participants

The study was carried out in 2 firms of a General Internal Medicine Clinic participating in the multi-site VA ACQUIP study.19 The ACQUIP trial used mailed alcohol-screening questionnaires to identify at-risk drinking and 5 other target conditions (depression, chronic lung disease, hypertension, coronary artery disease, and/or diabetes). Patients consented to participate in ACQUIP by completing and returning mailed questionnaires; all providers in the participating clinics were included in the ACQUIP trial. One of 2 firms at each site received the ACQUIP intervention. Providers in ACQUIP Intervention firms were prompted to address at-risk drinkers’ alcohol use by receiving a detailed report of patients’ alcohol-screening responses at each General Internal Medicine Clinic visit, along with reports for up to 5 other conditions. The audiotape study described in this report used ACQUIP’s alcohol-screening data to identify at-risk drinkers and compared discussions about alcohol use in Intervention and Control firms at 1 of 7 ACQUIP sites. The 6-month audiotape study began several months after the start of the 2-year ACQUIP trial.

All General Internal Medicine Clinic providers who were not involved in the design and institutional approval of this audiotape study were eligible to participate. Each provider practiced in only 1 firm of the clinic. Patients of consenting providers were eligible for the audiotape study if they screened positive for at-risk drinking (defined below) and indicated on a mailed ACQUIP questionnaire that they were willing to consider participating in an audiotape study of patient-provider communication.

Patients screened positive for “at-risk drinking” if they reported on the ACQUIP Screening Questionnaire that they drank any alcohol in the past year and scored 1 or more points on an 8-item augmented CAGE questionnaire.20 This augmented CAGE included the 4 CAGE questions (1 point each), a question asking whether the patient had ever had a drinking problem (1 point), and AUDIT questions 1 through 3 about the quantity and frequency of typical or episodic heavy drinking (1 point if ≥14 drinks/week on questions 1 and 2, and 1 point if ≥5 drinks on an occasion on AUDIT questions 2 or 3).20 This 8-item screening questionnaire is very sensitive (92%) with moderate specificity (50%) compared with an interview diagnosis of past-year hazardous drinking or active alcohol abuse or dependence.

We attempted to audiotape all General Internal Medicine Clinic visits of consenting patients during the 6-month study period. Patients and providers were blinded regarding the focus of the study on alcohol-related discussions and regarding the principal investigator (KAB), whose research related exclusively to alcohol. The investigator who presented the study to providers (CHB) was not involved with the ACQUIP study and studied ethical issues in primary care discussions. The University of Washington Human Subjects Committee and the General Internal Medicine Clinic approved the study, and all participating patients and providers gave written informed consent to participate in the audiotape study. Informed consent was first sought from providers and explicit consent was obtained for review of audiotapes by unnamed investigators.

Measures

We used 2 systems to code each utterance of alcohol-related discussions. The Motivational Interviewing Skills Code (MISC) system, developed by Miller and colleagues,21 was used to measure specific provider tasks (e.g., advice or feedback) and patient-centered behaviors (e.g., affirmation or reflective listening), as well as patient motivation. The MISC coding system is described in more detail below (see also Appendix A). In addition, to better understand the content of primary care discussions about alcohol, each patient or provider utterance during alcohol-related discussions was coded from transcripts into 1 of 3 content categories: 1) alcohol consumption or drinking pattern, 2) alcohol-related consequences (medical or otherwise), or 3) change in drinking (Appendix A). The first 2 content categories captured provider assessment and patient reports of drinking practices and related problems. The “change” category, viewed as an essential component of brief interventions, included: discussion of past treatment or change; recommendations for, consideration of, barriers to, and strategies for change; referral to treatment; or plans for future follow-up discussions relating to changes in alcohol use. Many utterances did not fit into these content categories and were coded as “not explicitly alcohol-related” (Appendix A).

Motivational Interviewing Skills Codes

We collapsed Motivational Interviewing Skills Codes into the following components of brief interventions with