Patient beliefs and attitudes towards the acceptability of receiving alcohol use enquiry from general practitioners: a literature review

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Abstract

Background: Routine use of alcohol screening questionnaires is recommended in primary care, but patient beliefs and attitudes towards the acceptability of receiving alcohol enquiry from GPs are unclear.

Methods: We searched medical databases to identify published empirical research on patient beliefs, attitudes and experiences towards receiving alcohol discussions from GPs. Coherent themes were synthesised from the results of the included studies using a realist perspective. Seventeen studies were included in the review – the majority were quantitative surveys from the UK, Nordic countries, North America and Australia.

Results and Discussion: GPs are seen to be legitimate providers of lifestyle advice, but patients may not find alcohol enquiry acceptable in a specific consultation. Alcohol discussions are less acceptable than those on other health promotion topics. The context of the consultation, such as the reason for presenting and the patient-doctor relationship, has an important influence on the situational acceptability of alcohol enquiry.

Conclusion: Although GP involvement in health promotion is perceived as legitimate, alcohol enquiry in consultations can be fraught and unwelcome. Contextual factors pertaining to the consultation appear to be important but these have not been well explored in the literature. Conclusions from this review should be restricted to societies with “Temperance” drinking cultures.

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1. Background

Since 1980, the World Health Organization (WHO) has advocated a preventive and health promotion based approach to reducing the harms from alcohol drinking [1, 2]. As general practitioners (GPs) have access to the at-risk population, often before the occurrence of alcohol-related harm, primary care was seen to be the key setting for the early detection of risky drinking, and the provision of brief alcohol interventions [3].

This strategy was supported by a multinational WHO collaborative project to develop an alcohol screening instrument specifically for use in primary care – the result of which was the Alcohol Use Disorders Identification Test (AUDIT) [2, 4]. This questionnaire has since been well validated in international primary care settings [5-7]. Brief alcohol interventions have similarly been studied in primary care and are thought to be effective in reducing alcohol consumption in risky drinkers [8].

This approach has also been adopted by policy makers of organisations representing preventive health and health promotion. For instance, Australian, UK and US peak body clinical practice guidelines all recommend that GPs routinely screen for risky drinking in adult patients using the AUDIT, or an AUDIT-based screening questionnaire, and offer brief interventions to risky drinkers [9-11].

However, there is consistent evidence that GPs do not use alcohol screening questionnaires [12-14], and that detection of risky drinking is low [15-21]. In addition to the pragmatic issues such as the time and resources involved in conducting screening and brief interventions for risky drinking [22], GPs have expressed concerns towards the impacts that alcohol use enquiry may have on the patient-doctor relationship and consultation [23] – for

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instance, uncomfortable with being seen as judgmental [24], or intruding into the patient's private life [25] or moral integrity [26-28].

Despite the growth in the body of academic literature on alcohol screening and brief interventions, there has been little research into how acceptable these interventions are to the intended recipients, i.e., community patients in general practice. This paper collates and attempts to provide a synthesis of the empirical evidence of patient beliefs and attitudes towards receiving alcohol enquiry. To our knowledge, no previous review exists.

2. Aim

To conduct a review of the literature on patient beliefs and attitudes towards the acceptability of receiving alcohol use enquiry from general practitioners (GPs) and to synthesise the findings.

3. Method

3.1 Search strategy

We conducted a search using Medline and Embase electronic databases in May 2014, using combinations of the keywords *"patient"*, *"alcohol"*, *"general practice"*, and *"primary health care"*.

Abstracts of the resulting articles published in English were reviewed against the inclusion criteria. Full-text copies of promising abstracts were obtained for further scrutiny, and an initial list of eligible papers was generated. Reference lists of the identified studies were

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examined for possible older studies – “backward chaining” [29]. We used *Web of Science* to conduct citation searching, finding who cited each of the identified studies to discover newer studies – “forward chaining” [29]. Both of these processes were also used on subsequent identified eligible articles iteratively to efficiently and comprehensively collate the relevant published literature in this field.

3.2 Inclusion/exclusion criteria

We sought to identify all empirical studies published after the WHO report in 1980 on patient beliefs, attitudes or experiences towards alcohol discussions with GPs in routine primary care settings. Studies were included if: (i) the study participants resembled a community general practice population, (ii) the research data were explicitly and directly gathered from the participants, (iii) the findings referred to services delivered by a GP in a primary care setting, and (iv) the study was published in 1980 or later. Thus, we excluded studies if the participants were all members of a specific disease group (e.g., studies of people with alcohol-use disorder), if the data collected were only second-hand (e.g., GP perceptions of patient beliefs and attitudes), and if the clinical setting was specialised (e.g., emergency departments or hospital outpatient clinics).

3.3 Quantity and setting of available evidence

The initial bibliographic search resulted in 631, and 938 study abstracts for inspection from Medline and Embase respectively. Of these, 6 empirical studies were found to be eligible for review. One of the authors, CT, through prior academic work had an existing list of important empirical studies on this topic. This, together with backward and forward chaining techniques identified 11 studies in addition to those from the initial search.

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The majority of the studies (15 of 17) were quantitative surveys conducted using a number of methods, including postal self-administered questionnaires, random telephone interviews, and exit polling after a GP visit (Table 1). There were two qualitative studies, one of which used mixed-methods (Table 2).

The UK was the most common location, accounting for 6 of the included studies. A further 5 were from Nordic countries. The remainder were from Australia, North America, and other European countries.

3.4 Analysis

We synthesised the results from the included studies using a realist qualitative approach. [30]. Briefly, this philosophic perspective involves ontological realism, "there is a real world that exists independently of our perceptions, theories, and constructions", with epistemological constructivism, "our understanding of this world is inevitably a construction from our own perspectives and standpoint" (p. 5) [30]. That is we assumed that (i) "patient acceptability" to receiving alcohol enquiry from GPs, and their beliefs and attitudes towards this are actual phenomena, and (ii) the empirical evidence from the included studies could inform us about these phenomena, but (iii) this evidence would be partial, interpretive, and not free from context. We chose this perspective in analysis as we recognised that broader social influences (e.g., drinking culture) may impact strongly on the beliefs surrounding risky drinking detection [23, 25, 31].

We extracted the relevant data from the included studies – the results, but also took careful consideration of the contexts and methods. Each study's demographics, recruitment, data collection techniques, and survey instruments were considered in the analysis. We discussed the possible limitations and biases of the included evidence, and how this may

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have influenced our interpretation of the results until consensus was reached. This process was framed by the perspective that a cohesive social phenomenon existed, and that the differences and apparent inconsistencies in the empirical data were explicable. Themes were synthesised from the construction of a coherent explanation of the evidence. Given the importance of context in our analysis, we reported on both how we understood the evidence-base, and our synthesis of the evidence in our results.

4. Results and discussion

4.1 Quantitative studies

Most of the included studies used quantitative methods. Wallace and Haines (1984) is recognised as one of the pioneering studies in the field of patient attitudes towards health promotion [32]. They developed and used a self-administered questionnaire, the Health Survey Questionnaire, which was subsequently applied in later study populations [33, 34]. The details and results of these studies are summarised in Table 1.

Although some of the results from these studies were not directly comparable, overall they suggested that patients were positive towards alcohol discussions with their GPs. However, there appeared to be striking variations in estimates between studies. In one UK study, only 52% of participants thought that their GP should “definitely” or “probably”, be “interested” in their alcohol drinking [33]. On the other hand, 92% of participants in a US study agreed with the statement “as part of my medical care, my doctor should feel free to ask me how much alcohol I drink” [35], and in another, only 1.8% of participants had a “negative opinion” towards a doctor or nurse talking about alcohol drinking with them [36].

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Results from two large recent studies suggested that there may be significant patient ambivalence towards alcohol enquiry from GPs. EUROPREVIEW, a cross-sectional survey conducted in primary care practices across 22 European countries, reported in 2012 that only 21.1% of risky drinkers would have liked to receive advice concerning alcohol intake from their GPs [37]. This was similar to an older finding that more than half of patients did not wish for advice on drinking [38]. Aligned with these results, a Swedish national survey published in the same year reported that 28.6% of participants agreed with the statement, "alcohol habits are people's own business and not something health care providers should ask about" [39]. Furthermore, the same study also found that 47.2% and 79% agreed that alcohol enquiry should only take place if the issue was brought up by the patient, or if the patient consulted the doctor with alcohol symptoms respectively [39].

4.2 Qualitative studies

There were only two studies that used qualitative methods, both from the UK [40, 41]. The details and results of these two studies are summarised in Table 2.

Stott and Pill (1990) conducted semi-structured interviews in the homes of the participants – a cohort of mothers of lower social class [40]. This study reported that although there were high numerical rates of agreement that GPs should have an interest in alcohol, the participants maintained that it was only appropriate if their health could be directly or potentially affected by this behaviour. There was a broad general agreement that alcohol advice was an extension of the GP role, but decision to take action ultimately rested with the individual.

Lock (2004) conducted focus group interviews of general practice patients from an area of England she noted had a strong culture of heavy drinking [41]. These participants revealed

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that when alcohol discussions occurred opportunistically, they responded to them well. They expressed the preference for these discussions to be conducted with GPs over other healthcare workers. An "appropriate" context was seen to improve acceptability – such as a "well man clinic" or "new patient registration". The participants also asserted that their relationship with the GP was an important factor in the acceptability of enquiry, producing positive and negative responses depending on existing rapport.

4.3 Understanding the evidence

It appeared that there was little clear empirical evidence available on the beliefs and attitudes that patients have towards alcohol use enquiry from GPs. Moreover, this evidence must be treated cautiously. The results of the two qualitative studies, which potentially provided a conceptual framework to understanding the contexts of the quantitative results, were limited by the narrow demographics of the participants. Results from the quantitative surveys could not be taken at face value – it seemed improbable that the very large variations between the numerical results of these studies represented actual regional differences. It may be that study contexts and methodological biases account for some of the inconsistencies in the quantitative evidence.

Firstly, survey respondents may have interpreted the wording of questionnaires in complex manners. For instance, although 84% of participants agreed that "health care providers should routinely ask about alcohol habits", paradoxically half also agreed that alcohol enquiry should only occur "if the issue was brought up by the patient" in the same survey [39]. This result highlighted a second issue – the use of fixed choices in surveys meant that little was actually known about the beliefs and attitudes that underlie the respondents' categorical answers [40]. It may have been that the participants interpreted the earlier

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statement as referring to the role responsibilities of a GP, and the latter to how he or she conducted the consultation, but this is conjectural. Stott and Pill's criticism in 1990 of the use of the survey method in understanding patient beliefs and attitudes in this field remains highly relevant to the present day [40].

Thirdly, bias from social desirability may be a particular issue. Alcohol problems are one of the most stigmatised health problems in contemporary society [42] and this seemed to have been reflected in some of the quantitative results. For instance in one study, less than 2% of participants self-reported that they had a problem with drinking, compared to 30%, 16%, 28% for a problem with weight, smoking and exercise respectively [33]. It is conceivable that the quantitative results were biased towards being more accepting and positive of alcohol discussions than in actual practice. This phenomenon could explain the particularly positive attitudes reported in face-to-face and clinic waiting room surveys [40, 43].

4.4 Evidence synthesis

4.4.1. GPs have a legitimate social role as providers of lifestyle advice

GPs seemed to have been viewed by patients as professionals with sufficient training and experience to deal with health and lifestyle problems, including alcohol. There were positive patient attitudes towards GPs taking a role in health promotion generally, though this might not translate to specific consultations. The giving of lifestyle advice was seen by some as an appropriate extension of a doctor's traditional role (Stott & Pill, 1990). If alcohol issues were discussed, there was some evidence that patients preferred this with GPs or practice nurses over other health professionals (Lock, 2004). It appeared that few patients held categorically negative views to GP alcohol enquiry [36, 43].

4.4.2. Alcohol discussions are less acceptable than those on smoking, exercise and diet

In surveys that measured patient attitudes towards discussions on a range of health promotion topics, respondents typically had less positive attitudes towards alcohol [32-34, 37, 38, 44]. EUROPREVIEW in particular demonstrated that risky drinkers were half as likely to have wanted advice, or believed that they needed to change compared to smokers, individuals with unhealthy eating habits, or those with a lack of physical activity [37].

4.4.3. The context of the consultation affects the acceptability of alcohol enquiry

Contexts such as the reason for presenting and the relationship between patient and doctor appeared to have an important influence on the legitimacy of GP alcohol enquiry. Alcohol discussions were seen to have been acceptable if the topic was brought up by the patient, or, if it was perceived by the patient to have been related to the reason they came. The theme that alcohol discussions should be linked to a current health problem was a reservation held by some participants across a number of studies [39-41]. In consultation with a trusted GP, the perception of sufficient consultation time might have been an incentive for patients to engage in alcohol discussions [41]. Patients have reported both positive and negative experiences to receiving alcohol discussions [40, 41].

4.5 Limitations

There are a number of important limitations to our analysis that need to be considered. Firstly, almost all of the included studies came from countries described as having "Temperance" drinking cultures (UK, Scandinavia, US and Australia) [45]. It is perhaps not surprising that the majority of this research came from countries that have been described as having a "morally charged relationship with alcohol" (p. 9) [45]. As there are large cross-

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cultural variations in attitudes towards alcohol, it is possible that our findings are culture bound and not applicable to countries with other drinking cultures.

Secondly, our literature search was limited only to publications in English. This was a pragmatic limitation. It was possible that we may have missed important non-English studies in our review.

5. Conclusion

The empirical evidence-base on patient acceptability towards receiving alcohol enquiry from GPs is limited in breadth and depth. A number of cautious conclusions can be made, and these should be restricted to societies with "Temperance" drinking cultures. Although GP involvement in health promotion was generally perceived as legitimate by patients, alcohol enquiry in consultations was not necessarily welcome. Overall, alcohol enquiry and alcohol discussions were less acceptable than other areas of health promotion (e.g., smoking, exercise and diet). Contextual factors pertaining to the consultation, such as the reason for the visit and the patient-doctor relationship, appeared to have important effects on the acceptability of alcohol enquiry. Details of these have not been well explored in the literature. Understanding these contextual factors may be crucial in implementing risky drinking early detection strategies that are acceptable to patients.

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1 **Table 1**

2 Included studies – quantitative surveys

Study	Method	Participants and Location	Findings (summary)
Aalto et al., 2002 [36]	Self-administered questionnaire given at the clinic	1,000 GP patients (67% response) Finland	69% positive opinion of a doctor or nurse talking about alcohol drinking 1.8% negative opinion
Aalto & Seppä, 2004 [46]	Exit poll survey of after GP consultations	2,000 GP patients (60% response) Finland	81% responded that discussions on alcohol were useful
Brotons et al., 2012 [37]	Self-administered questionnaire filled in the clinic	8,007 patients (7,947 analysed) 22 European countries	21% of risky drinkers would like to receive advice 30.5% of risky drinkers reported need to change
Eggleston et al., 1995 [38]	Self-administered postal questionnaire	1,639 GP patients (76% response) United Kingdom	51.4% do not wish for advice on drinking
Herbert & Bass, 1997 [47]	Self-administered postal questionnaire	860 GP patients analysed Canada	85% think doctors should ask about drinking behaviour
Johansson et al., 2005 [48]	Self-administered postal questionnaire	9750 GP patients (69% response) Sweden	62% of patients who expected alcohol advice received it Patients expected advice for alcohol less than for exercise, diet and tobacco use
Mäkelä et al., 2011 [43]	Random population survey – face-to-face interviews	2,725 community members (74% response) Finland	More than 90% had positive or relatively positive attitudes towards being asked about their alcohol use by their doctor or nurse
Miller et al., 2006 [35]	Self-administered waiting room questionnaire	187 GP patients (159 analysed) USA	92% agreeing that “as part of my medical care, my doctor should feel free to ask me how much alcohol I drink”
Nilsen et al., 2012 [39]	Random population survey – self-administered postal questionnaire	5,981 community members (54% response) Sweden	84% agreeing that health care providers should routinely ask patients about their alcohol habits, but; 47% agreeing that health care providers should only ask “if the issue was brought up by the patient”, and; 29% agreeing that “alcohol habits are people’s own business and not something health care providers should ask about”
Richmond et al., 1996 [34]	Self-administered waiting room questionnaire	14,725 GP patients (88% response) Australia	69% agreeing that GPs should definitely or probably be interested in their drinking
Rush et al., 2003 [49]	Random household telephone survey (Ontario area)	941 community members (65% response) Canada	79% agreeing that GPs should routinely ask patients about their drinking
Slama et al., 1989 [50]	Random household telephone survey (Newcastle area)	309 community members (264 analysed) Australia	80% would appreciate (definitely or probably) their GP asking about alcohol related problems 42% would appreciate their GP doing so on each visit

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Sullivan, 1988 [44]	Self-administered questionnaire given at the clinic	100 GP patients (86 analysed) United Kingdom	Lowest mean satisfaction score of 3.92 (range 3-5) when discussing alcohol, as compared to 9 other health promotion topics
Wallace & Haines, 1984 [32]	Self-administered postal questionnaire	3,452 GP patients (72% response) United Kingdom	80% agreeing that GPs should be interested in drinking problems
Wallace et al., 1987 [33]	Self-administered postal or clinic questionnaire	>70,394 GP patients (62,153 analysed) United Kingdom	52% agreeing that GPs should definitely or probably be interested in their drinking

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2 **Table 2**

3 Included studies – studies using qualitative methods

Author	Method	Participants and Location	Findings (summary)
Lock, 2004 [41]	Focus group study – qualitative thematic analysis	31 GP patients United Kingdom	Positive and negative beliefs and experiences Patients responded positively to questions and advice when in an appropriate context, and with practitioner with whom they have developed a relationship and rapport GP having the training and experience to deal with the problem Specific questions and advice were not always deemed to be appropriate or acceptable GP the preferred health professional to discuss alcohol issues, also because of good relationship or tradition Patients wanted to be praised and encouraged for trying to change behaviour Patients whose lifestyle behaviour was in excess had split views about the appropriateness of advice
Stott & Pill, 1990 [40]	Qualitative semi-structured interview in participant's home	130 mothers of lower SES United Kingdom	90% agreeing that GPs should definitely or probably be interested in their drinking, but for 41%, GP interest only appropriate if behaviour was linked to current illness/could lead to further problems Majority were broadly in favour of giving advice as an appropriate extension of the doctor's role Patients were anxious to assert the ultimate right of the individual to accept or reject advice and were aware of the constraints that might hinder the doctor undertaking health promotion The importance of the patient-doctor relationship was an explicit determinant of outcome, with patients rejecting advice from doctors who were not seen to care.

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