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Beliefs, attitudes and behaviours of general practitioners and general practice registrars in the identification of alcohol use disorders, and the AUDIT-C tool: focus groups of GP teaching practices

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Abstract

Background

At risk-drinking and alcohol use disorders are common in the Australian adult population. The lifetime prevalence of any alcohol use disorder, alcohol abuse and alcohol dependence is 22.1%, 18.3%, and 3.9% respectively; the 12-month prevalence figures are 4.3%, 2.9% and 1.4% [1]. Approximately a quarter of patients presenting to general practice are at-risk drinkers, though alcohol counselling/advice was given in only 3 in 1000 encounters [2].

Brief alcohol interventions are effective in the primary care setting [3] but problem drinkers need to be identified. The WHO developed ten-item AUDIT is a sensitive and specific screening tool. Unfortunately GPs found it awkward to use, impaired the patient-centred approach, and imposed too high a workload [4]. The three-item AUDIT-C tool is simpler and is similarly validated in primary care populations [5]. Its use is suggested by the Royal Australian College of General Practitioners to detect early problem drinking [6]. However, it is rarely used and identification of patients with problem drinking remains low.

This study is the first part of my research project investigating the gap between the detection of at-risk drinking and alcohol use disorders as suggested by the evidence-base, and the actual and pragmatic practice in primary care.

Aims

To qualitatively describe the beliefs, attitudes, and behaviours of Australian general practitioners in teaching practices, regarding the identification of patients with problem drinking, alcohol screening, and the AUDIT-C tool.

Method

General practices affiliated with GP Synergy Ltd in metropolitan Sydney that employed and trained GP registrars were approached by the lead investigator to participate in the study. A focus group of 4-8 participants (GP supervisors, registrars, other doctors) was run in each participating practice. Demographic information of the participants and practices was collected with a brief self-

administered questionnaire. Five main questions were used as triggers: "what proportion of adult patients do you think drink at at-risk levels?", "what do you think of identifying patients with problem drinking in primary care?", "how do you currently identify these patients?", "what do you think of routine alcohol screening?", and "what do you think of the AUDIT-C tool?". The audio was digitally recorded, transcribed, and de-identified. Transcripts were analysed using NVivo9 software. Free coding was used initially to capture themes as they emerged from the transcript. Themes from earlier focus groups were explored in latter focus groups in an iterative process. The data was sorted and analysed using a grounded theory approach. It is expected that 4 to 6 focus groups will be required to reach saturation.

Results

The study is currently ongoing; these are preliminary results.

Three focus groups have been conducted to date with a total 17 participants. All three general practices were: in metropolitan Sydney, group practices, appointment based, "well established" and used "Best Practice" clinical software. An average of 8 doctors worked in each practice. Of the participants, 7 were male and 10 female. They worked an average of 30 hours per week, saw 77 patients, with an average appointment length of 16.5 minutes. Four of the participants have prior work experience in a drug and alcohol unit. The participants include: 7 GP supervisors (mean age 51 years) with extensive general practice experience (average 22 years as GP), 4 GP registrars, 5 other GPs, and 1 PGPPP.

Dominant themes that have emerged in the three focus groups:

1. **Impact of the doctor-patient relationship**; the participants believed that the doctor-patient relationship was very important and needed to be maintained. The GP agenda of identifying problem drinking may pose a potential threat to the relationship, depending on the patient's agenda. A number of factors which may increase or decrease the threat to the doctor-patient relationship were identified.
2. **Beliefs and attitudes on the detection of problem drinking**; the participants believed that assessment of alcohol consumption was important but that precision was required. They held realistic estimates of problem drinking prevalence. They had both positive and negative beliefs of their effectiveness as clinicians. The participants identified a number of barriers: difficulty in obtaining an accurate alcohol history, belief of ineffectiveness in promoting behaviour change, time pressure, issues with recording information and labelling problem drinkers, and issues surrounding the doctor as a drinker.
3. **Beliefs and attitudes on alcohol screening tools**; the participants held positive beliefs about alcohol screening *conceptually* but negative views about their use *pragmatically*. They did not use screening tools for the purposes of screening. When introduced to the AUDIT-C tool, the participants believed that it was quick, and that the questions were useful. However, the scoring was not perceived as face valid; it was severe and lacked specificity.
4. **Impact of social attitudes and the culture of drinking**; this theme emerged from the discussion and unlike the other themes was not prompted. The participants believed that there was a tension between the label of problem drinking (stigmatised) and the practice of problem drinking (socially acceptable), and that this had a number of impacts on how it was perceived within a consultation.

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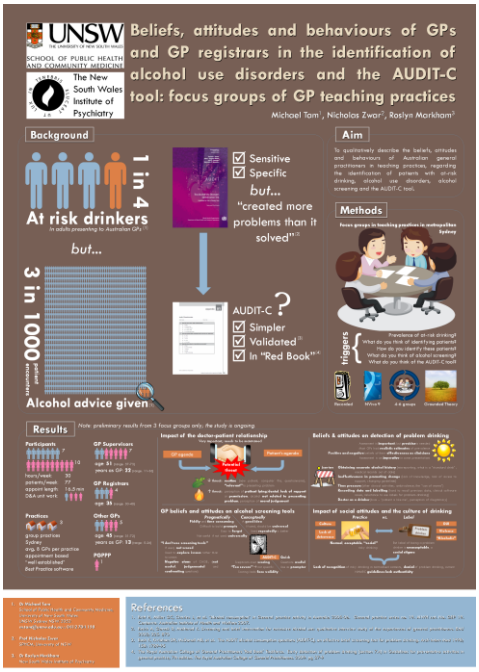

Website

The poster and handout used at the GP11 Conference Hobart, 6 October 2011, can downloaded from:

wp.me/P167Tm-o4

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