Seeing through the glass darkly? A qualitative exploration of GPs' drinking and their alcohol intervention practices

Eileen Kaner, Tim Rapley and Carl May


Background. Brief alcohol intervention is influenced by patients’ personal characteristics as well as their clinical risk. Risk-drinkers from higher social-status groups are less likely to receive brief intervention from GPs than those from lower social-status groups. Thus GPs’ perception of social similarity or distance may influence brief intervention.

Objective. To explore the role that GPs’ drinking behaviour plays in their recognition of alcohol-related risk in patients.

Method. A qualitative interview study with 29 GPs recruited according to maximum variation sampling. All interviews were audio-recorded and transcribed verbatim. Analysis was inductive with constant comparison within and between themes plus deviant case analysis. Analysis developed until category saturation was reached.

Results. GPs described a range of personal drinking practices that broadly mirrored population drinking patterns. Many saw themselves as part of mainstream society, sharing in culturally sanctioned behaviour. For some GPs, shared drinking practices could increase empathy for patients who drank, and facilitate discussion about alcohol. However, several GPs regarded themselves as distinct from ‘others’, separating their own drinking from that of patients. Several GPs described a form of benchmarking, wherein only patients who drank more, or differently, to themselves were felt to be ‘at risk’.

Conclusion. Alcohol is clearly a complex and emotive health and social issue and GPs are not immune to its effects. For some GPs’ shared drinking behaviour can act as a window of opportunity enabling insight on alcohol issues and facilitating discussion. However, other GPs may see through the glass more darkly and selectively recognize risk only in those patients who are least like them.

Keywords. Alcohol, brief interventions, general practitioners, primary care.

Background

Alcohol contributes 4% to the total disease burden worldwide, as measured by disability-adjusted life years (DALYS). This burden is more evident in developed countries (9% DALYS), where alcohol ranks third after smoking and hypertension as the lead cause of morbidity and premature death. In community-based health services, one-fifth of patients are likely to be excessive drinkers, presenting at twice the rate as average patients with a wide range of alcohol-related problems. Moreover, it has been estimated that 1 in 15 doctors themselves may, at some time, experience problems with drugs or alcohol. Thus alcohol-related risk is likely to be both professionally and personally relevant to GPs.

Primary care is ideal for early detection and secondary prevention of alcohol-related problems due to its high contact-exposure to the population. Moreover, excessive drinking responds to brief intervention. Over 34 trials have evaluated brief interventions in non-treatment seeking patients attending primary care, with consistently positive findings. Thus recent research has focused on implementing brief alcohol...
interventions in routine primary care across a number of countries. However, inconsistent delivery of brief interventions has been reported for both GPs and primary care nurses, and this form of preventive care seems to be influenced by patients’ personal and social characteristics.

It has long been known that typification of patients by clinicians can play a role in determining care and socially-patterned differences in care have been reported for such diverse areas as mental health, preventive care, prescribing, consultation length and surgical intervention. Where alcohol intervention is different from other clinical issues is that its delivery pattern by GPs reverses the usual inverse-care law. Patients from higher social-status groups tend to under-receive brief alcohol intervention from GPs and vice versa. Exploration of factors influencing alcohol intervention list socio-emotional issues such as topic sensitivity, fear of negative reactions and anxiety about harming the doctor–patient relationship as well as practical issues such as time and lack of skills or support. These reasons explain a general lack of engagement with alcohol-related work but not selective engagement with certain types of patients.

A significance feature of alcohol consumption is that it is often shared by patients and clinicians alike. Drinking alcohol constitutes part of everyday living for many individuals and generally involves a degree of choice. Thus, in contrast with non-volitional clinical issues, where professional detachment may be more simple, clinicians may find it difficult to recognize alcohol-related risk if they identify with drinking behaviour. Excessive drinking has been described in GPs recently qualified doctors and student doctors. However, little is known about whether doctors’ drinking affects their detection and management of alcohol-related problems. This paper explores the influence of GPs’ drinking on their recognition of alcohol-related risk and their engagement with alcohol-related work. The study was part of a broader investigation of the relationship between clinical evidence and practical experience in shaping alcohol-related practice.

Methods

This qualitative study was undertaken between 2003 and 2004, in the north of England. The research was undertaken in two phases. In phase 1 we undertook semi-structured interviews, lasting between 45 and 90 minutes, with 29 GPs recruited according to maximum variation sampling on the basis of gender, work pattern, practice location, clinical experience and prior involvement in a brief alcohol intervention trial (see Table 1). In these interviews we explored the relationships between clinical evidence and day-to-day experience in shaping practice and we asked participants to review cases of specific patients with alcohol-related problems (topic guide available on request). GPs’ drinking behaviour was an emergent issue from earlier interviews that was further explored in later interviews. All interviews were conducted by a social scientist (TR) with extensive experience of field research. Field notes were written up after each interview to capture details of practice, personal and interpersonal context.

In phase 2, we undertook three task-group interviews with GPs (n = 14) and other professionals (n = 5) which lasted between 70 and 90 minutes. Two task-groups consisted of only GPs and one involved a primary care team at the GPs’ request. In the group interviews we offered the preliminary results of the one-to-one interviews. Respondents then discussed, challenged and enhanced our findings.

Following the broad precepts of the constant comparative method all interviews were audio-taped, transcribed and anonymized. Analysis was inductive (i.e. constant comparison within and between themes and deviant case analysis of outlying themes). The analysis developed until category saturation was reached (i.e. interviews and analytic procedures yielded no new

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material for analysis). The analysis was further developed and validated through the group interviews. Group interview data supported earlier findings but for brevity we have presented illustrative extracts from the one-to-one interviews.

This study was approved by the Northern and Yorkshire Multi-centre Research Ethics committee and local area approval was granted by all relevant local research ethics committees. Research governance approval was also obtained from all Primary Care Trusts in the study area.

Results

**GPs’ relationship with alcohol**

In six interviews, GPs’ drinking was neither volunteered by subjects nor raised by the interviewer. In field notes, the interviewer (TR) noted caution about raising/pursuing the matter with some subjects due to moments of unease during the interview. As a testament to this sensitivity, four respondents deflected the conversation from their own drinking behaviour either via humour ‘Talking to people with a problem . . . I’ve no problem at all, no I was only joking . . . oh it’s only a bottle of wine at night (both laugh) it’s neither here nor there is it’ (GP13M: 175–186) or by discussing doctors in general or societal drinking patterns.

However, 19 GPs explicitly discussed their own alcohol consumption. Whilst one subject described himself as a life-time abstainer from alcohol, the remainder described a range of drinking practices that broadly mirrored population drinking patterns (see Box 1). Although no GP reported direct experience of alcohol dependence, one described a practice partner as an ex-alcoholic.

GPs reported a variety of personal and social reasons for drinking (see Box 2) and they also described experiencing adverse effects such as hangovers, finding it difficult to estimate quantities drunk or occasionally having difficulty limiting consumption. One GP reported significant, personal problems due to a spouse’s drinking.

A number of subjects felt that doctors, in general, often drank heavily and could develop problems with alcohol. However, they added that doctors’ problems were harder to detect than those of patients ‘that’s not to say that doctors don’t get drunk or don’t have a dependency problem sometimes but it’s more disguised’. (GP15M: 160–176). It was clear that there was embarrassment surrounding the subject of alcohol-related problems in doctors and how to tackle them.

‘you tend to assume that problems are other peoples . . . so you’d probably have more difficulty, you know, if I had a female GP come to see me, who was drinking too much, I would find it more difficult to confront her about it. Or it could be a man I suppose.’ (GP12F: 779–783)

The difficulty for GPs in accessing alcohol-related care themselves was also mentioned ‘there’s plenty of doctors who have drink problems you know but . . . I wonder where they go’ (GP27F: 680–681). Although, one subject reported that seeing colleagues for alcohol-related problems was a feature of age and experience.

‘as I hinted earlier, doctors aren’t above this and as we get older you end up seeing most of your colleagues either professionally, I don’t actually have any GPs or doctors on my personal walks, but I have quite a lot who unfortunately come in and see me, an interesting thing is that they always bring you a bottle of something.’ (GP28M: 764–778)
Box 2  GPs’ reasons for drinking

Relaxation/stress relief
‘When I switch off at night I have two glasses of wine (laughs) and if we’re having a really good night we have friends round we all drink too much and... errrm... y’know we all... we all work at a hundred and twenty per cent these days... going home and having a couple of glasses of wine is a very easy way to switch off... I don’t deny that I have a couple of glasses of wine... late evening just to... sort of switch off but would never have more than that ermm but I’m sure there’s an awful lot of people who would be so easy to have three or four glasses and not even think about it... and they may wake up in the morning and feel fine’ (GP27F: 216–331)

Enjoyment
‘We’re almost coming to a sort of exhausted society of preventative measures and I wonder just how far we can go before we make life really miserable for everyone and I’m sure though that in... that involves my own personal perception, what alcohol does for me and how much I enjoy alcohol y’know and how giving it up I could see as being a bit of a loss, so very intensely personal whereas smoking y’know I’m very anti... I’ve a great antipathy for smoking (GP5M: 100–131)

Habit
‘I do y’know... there’s a Friday night feeling, is that psychologically addiction? I mean I get that...I’ve never been in a position where the amount that I’ve drunk has really done me any serious harm, I mean... I’ve had a hangover’ (GP22F: 49–103)

Socialising
I mean for personal alcohol consumption I probably drink four or five pints a week and hmmm...there are times when I feel guilty and there are times when I drink more than I should do, more than is good for me... I think maybe I get sucked into social situations sometimes when I shouldn’t be (GP 26M: 720–728)

Box 3  GPs’ insight into excessive drinking

‘we did keep an alcohol diary ourselves just to see how that felt and to tie it up [and how did that feel] well, a little bit threatening, I mean I think that...I mean I don’t know if we are going to move onto that but...I mean what relationship is with your own personal consumption and advising your patients on... but it was a bit threatening and you were wondering, you know, exactly how honestly to report it, you know that night down at the pub did it really have to be at the week that you were recording it, you know, so it is a little bit difficult in terms of temptation to not... to not reply honestly...type of thing’ (GP26M: 319–339)

‘You know, it’s quite easy to drink a lot isn’t it and, you know, you don’t realise quite ‘cause it is easy to identify with er, drinking too much. Em, ‘cause it would be quite easy to do and personally I have actually, after I discovered there were eight units in a bottle of wine I’ve drunk less ‘cause I decided I’d better. I hadn’t realised, I think I was drinking more units than I thought I was. But no, I don’t find it difficult to raise usually at all. I suppose maybe that comes back to in this country it’s not, you know, to say you drink a fair amount isn’t, isn’t something that’s a stigma really is it.’ (GP14F: 808–826)

‘Erm, well this, this is why I said half an hour ago y’know, you or I could be an alcoholic and y’know don’t look like we are but we’re well educated y’know professional jobs erm that doesn’t isolate you from the possibility of becoming alcoholic or y’know sorry y’know or abusing it’ (GP15M: 1053-1081)

‘I don’t know why I use “use”’. Em, I guess “cause alcohol’s so complicated, you know, it’s kind of socially legitimate and I use it myself em, and em, and, and at the same time it’s a big, it’s a big (laughing) problem for lots of people so it’s a sort of neutral word isn’t it. (GP18M: 47–65)

Personal identification or professional detachment
A number of GPs described their drinking as an activity shared with the majority of the population. Alcohol use was felt to be socially sanctioned due to its licit status ‘it’s a legal drug, y’know, and we all drink, doctors more than most’. (GP15M: 88–112) and heavy drinking was thought to be increasing amongst doctors, as with the rest of the population. The shared nature of alcohol consumption could enable insight and increased empathy concerning excessive drinking in patients (see Box 3).

In contrast, some GPs regarded themselves to be different from ‘other people’. This difference was described in terms of their comprehension of, or receptivity to, public health messages.

“I know what’s good for me and what’s not good for me and it seems to be incredible that there’s anybody left in the country smoking, because it’s like smoking kills in big black letters on a packet of cigarettes, would you buy anything else with that on? But they’re smoking in their millions...I would say that alcohol is more socially acceptable than smoking and that there isn’t, there isn’t the information out there but I, I mean I know it so I think how does everybody else not know?’”(GP 22F: 337–377)

A number of GPs actively distanced their own drinking from the health advice they gave to patients. In essence, they separated personal and professional personas, resulting in disparity between what they did and said.

“Well I think for a long time em, I used to smoke and give people anti-smoking advice so I’ve completely distanced what I do and what I say. So I don’t, I don’t find that too much of a problem. It doesn’t make me address my own alcohol problems when I’m talking to other people, but I think I’ve learned to switch that off... but at the end of the day em, ... I wouldn’t have any justification for not telling somebody with a chronic cough to stop smoking just because I smoke. So no, it didn’t stop me at all and I did it without any problem... I would only have felt guilty if they’d seen me in the...
For many GPs though, alcohol was clearly an emotive issue. Various subjects expressed guilt about their own consumption, anxiety about hypocrisy due to engaging in a behaviour that they were trying to reduce in others, embarrassment about discovering heavy drinking in patients, being troubled about alcohol as a health and social issue and feeling frustrated about the refractory nature of alcohol-related problems, particularly in alcohol-dependent patients.

A familiar refrain in many interviews was that a problem drinker was someone who drank more than their doctor. This adage was volunteered by several GPs and also recounted as a view often held by patients. It is difficult to unravel how much this rhetorical device was used humorously or as a serious point, referring to the shared cultural basis of drinking. Nevertheless, there was clear personalisation in many GPs’ accounts of alcohol-related work.

**Personal bench-marking and judgement about risk**

Several GPs used their own drinking as a benchmark, beyond which they determined that patients were ‘at-risk’ due to alcohol consumption and requiring intervention (see Box 4). For some GPs, this benchmarking was abstract, concerning others’ practices ‘I am sure there are a lot of doctors who are drinking too much, it’s a fact isn’t it, they’re drinking too much themselves, and I mean that must affect your threshold for talking about it’ (GP25F: 739–767). For others, it was a concrete account of their own practice.

Benchmarking could help to normalize patients’ drinking by placing alcohol within the realm of common behaviour. Thus some GPs’ reported using their own drinking experiences as a device to initiate alcohol-related discussions with patients.

“I mean with younger people y’know you can cheerfully say well yeah y’know I always have nights when I drank more that I should have and I’ve done things I shouldn’t but y’know it’s important to make sure that doesn’t reflect on your health too much in the future’ y’know and you can make it quite light hearted.” (GP8F 821–831)

However, bench-marking could also be used by GPs to rationalize their own drinking ‘even if you drink too much as a GP you probably try and normalize a lot of the time and tell yourself that’s just a healthy intake’ (GP9M 72–93). Furthermore, by using themselves as the yardstick some GPs were able to overlook external guidelines on sensible drinking.

“I’d like to think I vaguely stick to the limits possibly most of the time and that’s I don’t, I’m not looking at it any harder than that, erm and for patients I would, I would probably be advising them the same way as I would be advising me.” (GP22F 49–103)

**Subjectivity and clinical intervention**

Finally, several GPs felt that alcohol-related discussion was as much determined by their personal qualities such as confidence or directness, and perceptions about consultation dynamics, as by patients’ risk-status (see Box 5). Thus confirming that personal and social factors interact with clinical information to influence alcohol intervention.

**Discussion**

Alcohol has long been regarded as a ‘difficult business’ for primary care and indeed alcoholism the dirty work of medicine. Part of this difficulty derives from the fact that problem drinking is ill-defined, multifaceted and surrounded by arbitrary notions such as ‘social drinking’ and ‘safe limits’. Thus it may be difficult to establish
Clinicians’ personal and social characteristics are likely to influence their own health behaviour and risk-taking activity. However, our data suggest that clinicians’ personal and social characteristics may also influence their perception, or indeed recognition, of health risks in others and their tendency to deliver preventive care to different ‘types’ of patients. The latter is little explored in the healthcare literature and requires further careful research including whether inconsistent delivery of preventive care extends beyond alcohol to other lifestyle issues such as obesity or smoking.

The current study was a qualitative exploration with GPs currently practising in the North of England. Subjects were selected to maximize variation of perspectives and achieve a saturation of views about the issue being studied. Thus these findings may not generalize to other health contexts or cultures. Furthermore, subjects self-selected into the study and may have had a particular interest in alcohol or research. Thus they may not represent the views of GPs more generally. However, a strength of this detailed exploration is that we did not set out to focus on GPs’ drinking per se but this issue was raised by GPs themselves as a salient factor. Later task-groups provided an authenticity check on this interpretation. Moreover, the fact that potentially ‘interested’ GPs described contingent risk identification and intervention raises the possibility of greater inconsistency in the wider GP population. Finally, this qualitative work suggests that clinicians’ relationship with alcohol can influence alcohol intervention. These data may help explain qualitative research findings of widespread inconsistencies in brief alcohol intervention delivery. The triangulation of qualitative and quantitative research data highlights a new avenue for future research attention that examines the possible link between clinicians’ personal behaviour and their preventive practice.

In conclusion, risky drinking has been reported in doctors but such survey data cannot explore subjects’ views about their drinking nor its impact on alcohol-related care. Previous work has highlighted general sensitivity surrounding alcohol in GPs’ practice but not its personal relevance for them. It has long been known that making a clinical diagnosis is not merely an intellectual exercise, but that it has emotional connotations for both patients and doctors. Alcohol is clearly a complex and emotive health and social issue for clinicians, politicians and the general public. GPs are not immune to its effects. For some GPs’ shared drinking behaviour can act as a window of opportunity enabling insight on alcohol issues and facilitating discussion. However, other GPs may see through the glass more darkly and selectively recognize risk only in those patients who are least like them.

**Box 5 Personal and social context determining alcohol intervention**

> ‘Well I think this is, you know, a feature of me rather than er alcohol probably, er, you know, I’m just used to... I’m a quite direct person and always have been, particularly at work, that’s always seemed to be quite an effective strategy and I mean maybe the people who don’t like it go to someone else (laughs) but I’ve never... I don’t feel embarrassed particularly about asking. I mean there’s a lot worse things you have to ask people about, you know, than how much you’re drinking... it is easy to identify with er, drinking too much... after I discovered there were 8 units in a bottle of wine I’ve drunk less (interviewer laughs) ‘cause I decided I’d better’. (GP14F: 808–826)

> ‘If the consultation is going well and you are, feel you are, establishing a rapport with the person I think you can address anything no matter how awkward... But if that consultation isn’t feeling comfortable, you are not going to make it more uncomfortable by addressing something that you perceive might cause more barriers... So... yes, so if you’ve got somebody who has been kept waiting and they are not happy about something, you are not going in and saying ‘and you drink too much’, you just think ‘no, no I’ll mention that another time’ or I’ll just not bother, you know, we will just try and keep things sweet as it were’ (GP12F: 111–129)
Acknowledgements

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EK and CM were responsible for obtaining the research grant. TR carried out all interview work. The nature of the enquiry developed as the study proceeded and all authors were responsible for shaping the ongoing study. TR prepared an initial data summary and EK carried out the main data analysis. EK prepared the initial manuscript and all authors contributed to its final version.

References