DISCUSSING ALCOHOL IN MEDICINES USE REVIEWS: EXPERIENCES OF PATIENTS IN A COMMUNITY PHARMACY CONTEXT

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STATEMENT OF AUTHORSHIP

All authors have made substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work, drafted the manuscript and/or revised it critically for important intellectual content, approved the version to be published, and agree to be accountable for all aspects of the work.

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Abstract

Objectives

Although pharmacist-led medicines use reviews (MURs) are effective for medicines management, little is understood about patients' experiences of alcohol-related advice delivered therein. Sampling a population at high-risk for misuse (within an area of socioeconomic deprivation), we explored patient experiences of alcohol-related MURs.

Methods

Two focus groups were conducted with patients who had discussed alcohol in an MUR in the preceding three months (n = 9). Data were analysed thematically.

Key findings and conclusion

Patients were open to discussing alcohol in the MUR context. The absence of practitioner-patient power asymmetry, and pharmacists' sensitivity to cultural contexts, were critical to patient engagement.

Key words: Alcohol use, medicine use review, healthy lifestyle, community pharmacy

INTRODUCTION

Alcohol misuse is a public health priority. UK guidelines recommend regular opportunistic intervention from practitioners[1]. Pharmacist-led medicines use reviews (MURs) present one such opportunity, yet patient perceptions of alcohol-related advice within this setting are unclear.

Work that considers patients' experiences of pharmacy-based public health services tends to use quantitative methodologies rather than deep engagement with patient experiences.[2,3] Moreover, limited attention has been paid to the needs of communities who are more challenging to recruit to interventions and achieve poorer outcomes despite high need and pharmacy accessibility.[4] In socioeconomically deprived areas, alcohol consumption generally exceeds recommended guidelines and alcohol-related ill health is disproportionately likely[5]. In these areas, there is likely to be a greater power asymmetry between healthcare practitioners and patients that may lead to sub-optimal advice-seeking[6].

The present study collected descriptive qualitative data about alcohol-related MUR discussions from patients in an area of high deprivation. The objectives were to: (i) explore patients' experiences of alcohol-related discussions within MURs; and (ii) understand the particular experiences of patients from socioeconomically deprived areas vis-a-vis pharmacy-based alcohol-related discussions.

METHODS

Context

The study, which was conducted as a final year MPharm project, took place in Middlesbrough, North-East England, where 48.8% of neighbourhoods are among the 10% of most deprived in the UK[7]. Participants were recruited through an independent community pharmacy which has two pharmacists, six support staff and counter assistants; is a level 2 Healthy Living Pharmacy; and is attached to a therapy centre offering massages and reflexology. All research team members are independent from the pharmacy. Ethics approval was given by Durham University's School of Medicine, Pharmacy and Health Ethics Committee (Reference:PESC_Proj2016_22_WhittleseaCM).

Participants

8 males and 1 female, aged 63-77, were purposively sampled after having discussed alcohol consumption in an MUR within the preceding three months. All had one or more chronic conditions (Table 1). Individual-level socio-economic information was not collected; all lived within the selected area of interest for the study..

[Insert Table 1 about here]

Data Collection and Analysis

Two focus groups were held in November/December 2016. Focus group 1 had four participants and focus group 2 had five. Each lasted approximately one hour and was audio-recorded. Focus groups were facilitated by a semi-structured topic guide covering; (i) study information, (ii) perceptions of MURs, (iii) participants' recent MUR consultation, (iv) discussing alcohol within the MUR, and (v)

summary. Following verbatim anonymised transcription by AP, the data were analysed thematically using Barbour's[8] five stage approach.

RESULTS

1: Openness to discussing alcohol

Participants did not see alcohol consumption as a sensitive subject to discuss, recognising such discussions as providing supportive advice. Willingness to engage was associated with a personalised and caring approach by the pharmacist:

> *"he [the pharmacist] is so open… He's very concerned about you" (P1, FG1)*
>
> *"You feel you're being dealt with personally… which is absolutely excellent" (P4, FG2)*

2: Assisting understanding

Participants reported finding official guidelines "*extremely confusing*" given information relating to alcohol changed regularly:

> *"I think, one of the big problems… the NHS, doctors have, whatever, is… I believe a lack of confidence in statements that saying... so many units is- over so many units bad for you because it's changed over the years" (P9, FG2)*

MURs were recognized as *"very informative"* for making sense of this information. Participants were receptive to discussions about interactions between medication and alcohol, but still expressed some lack of trust in the quality of this information:

> *"If [the pharmacist] actually said to me, right, this medication – really, you should not drink any alcohol, I would feel comfortable in saying to him, why? Can we talk about it? And I'm not gonna say or promise I believe him, but I would listen to him, and I would make a judgment" (P9, FG2)*

3: Cultural drinking norms

Participants used the MUR to reflect on wider social and contextual influences on their alcohol use. Occupational settings and norms were recognised as facilitators of alcohol consumption:

"we go to lots of company functions… We're staying in a hotel, and everybody'll be drinking" (P5, FG2)

"getting ready for a shift change-over, and they'd have a tray ready with.. a dozen half-pints, ready pulled" (P7, FG2)

Within these social spaces, participants reporting failing to monitor drinking or were dishonest when it was discussed. Given this, participants recognized the benefits of pharmacy-based MURs as providing a safe space for discussing alcohol, acknowledging the sensitivity of the pharmacist regarding this:

"it's more, amenable to talk here, about it because I- I can be honest and don't feel, that people are going to be judgmental" (P9, FG2)

4: Benefits of pharmacy-based interventions

Participants highlighted community pharmacy accessibility and pharmacist approachability as beneficial. This was contrasted with experiences of other healthcare practitioners (namely GPs) where participants perceived a power imbalance:

"And they [GPs] quite pointedly tell you, well, I've.. ten minutes.. . and you feel rushed, and there's something else you'd like to ask, but you've got to go…" (P8, FG2)

"Maybe it's just me, but I find my GP's more judgemental" (P8, FG2)

"strict and overpowering I find, the doctor" (P5, FG2)

DISCUSSION

In summary, the study found that patients perceive community pharmacies as appropriate and supportive environments for alcohol-specific advice if approached in a non-judgmental way. Pharmacists were seen as key practitioners for helping patients to navigate the complex, and sometimes contradictory, informational landscape.

There are limitations of the study: (i) the sample was relatively small and homogenous; (ii) data were from one site; and (iii) we did not specifically recruit socio-economically deprived participants. However, the study provides a strong foundation for future research on alcohol-focused conversations in community pharmacy settings.

United Kingdom guidelines recommend regular and opportunistic intervention when patients are in contact with practitioners. Brief interventions (i.e., a single conversation/session) have demonstrated small but clinically meaningful effects on alcohol use for adults, especially when delivered in primary care settings.[9]

The present findings demonstrate that MURs represent appropriate and acceptable encounters in which to open such conversations. The article highlights benefits of community pharmacies for providing alcohol-related advice. Community pharmacists have been identified as the first port of call for patients for health advice. Such accessibility is particularly pertinent in areas of high deprivation where pharmacists are accessible[5] and where the power asymmetry between doctors and patients might be most keenly felt[6].

The findings show that patterns of alcohol consumption are culturally-located and sometimes endemic in working practices. Therefore, interventions need to be appropriately positioned,[10] with advice making sense within patients' cultural

contexts. Future research should work *with* deprived communities to develop culturally-meaningful information resources, conveyed *through* respected channels and *within* pertinent environments. A larger scale exploration of patient experience across a variety of delivery sites may give more nuanced understanding.

CONCLUSIONS

Community pharmacy MURs were perceived by participants as useful and appropriate for alcohol-related discussion. This may be particularly the case for individuals from deprived areas contending with drinking cultures linked to social and working lives, alongside a wariness of more medicalized settings. Pharmacists are well-placed to bridge the gap between guidelines and daily experiences of clients, and discuss the place of alcohol in patients' lives.

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1 Table 1: Participant characteristic data

Group characteristic	Prevalence and description (number of participants)
Age range	63-77
Gender	Male (8), female (1)
Disease and medication factors	Diabetes (3), cardiac disease (5), blood pressure (1), migraines (1) arthritis (1).
	Beta blocker (2), statins (3), NOACs (1), metformin (3), opioid analgesics (2).
	Did not comment on their disease or medication factors (1).
Lifestyle and alcohol factors	Regular exercise (3), occasional exercise (3), previous competitive exercise (2), carer (1).
	Drinks alcohol most days (3), occasional drinker (3), rarely drinks (2), information not provided (1).

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