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Patient perspectives on discussing alcohol as part of medicines review in community pharmacies.

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Abstract

Background

This paper reports on a qualitative study which formed part of the intervention development phase of a five year research programme (Community pharmacy: Highlighting Alcohol use in Medication appointments; CHAMP-1).

Objectives

To better understand patient views on the appropriateness of alcohol as a subject for discussion in medication reviews in community pharmacy.

Methods

Semi-structured interviews were conducted with a sample of 25 people eligible for medication reviews whose AUDIT-C screening scores identified them as likely risky drinkers. Transcripts were analysed using a modified framework method with a constructionist thematic analysis approach.

Results

Most patients interviewed said they were open to the idea of a medication and alcohol linked discussion with a pharmacist if this was routine, well-conducted and confidential. Such a discussion was thought less personally relevant for those who viewed the proposed intervention through the prism of a particular set of ideas about the nature of alcohol problems, which distanced them from thinking about alcohol in terms of their everyday life and possible impacts on their health. Study findings attest to some of the sensitivities involved in discussion of alcohol, and the complexities inherent in helping people to talk about their own drinking, medicine use and health.

Conclusions

Patients were open to the idea of discussing alcohol with community pharmacists in the context of a medicines review if this was sensitively done and the relevance was clear to them.

Key words 6 (US spelling)

Community pharmacy, medicines review, alcohol, brief intervention, qualitative research

Introduction

The majority of people in England drink alcohol and its consumption is commonly associated with pleasure, recreation and celebration. Alcohol is deeply culturally embedded in this country. However, a substantial number of people experience harm from their own or others' drinking.¹ Hazardous drinking is consumption at levels which increases the risk of chronic physical and mental health morbidities, including gastrointestinal disorders (especially liver and pancreatic disease), cardiovascular diseases, depression, anxiety and cancers or acute intoxication-related injuries or violence.² Harmful drinking involves drinking that involves any of these or other health and social problems.

Drinking prevalence among adults in England has fallen over the last ten years, with those aged 55-64 most likely to be drinking at hazardous levels.³ Many such drinkers are eligible for medicines reviews on the grounds that they have existing long-term conditions or are taking multiple medicines. Others participating in medicines reviews may be drinking at lower levels which nonetheless involve potentially adverse impacts of alcohol on the use, safety and effectiveness of their medications. Thus, both the conditions and their treatment may be adversely affected by alcohol consumption.

NHS England contracts community pharmacists to deliver Medicines Use Reviews (MURs) and the New Medicine Service (NMS) to improve patients' medication adherence, improve understanding and reduce avoidable medicines waste.^{4 5} Patient eligibility for MURs has changed over time. At the time of this study eligible groups were: patients taking high risk medicines; patients recently discharged from hospital where changes had been made to their medicines; patients with respiratory disease; and patients at risk of or diagnosed with cardiovascular disease regularly prescribed at least four medicines. Patients eligible for the NMS were those prescribed a new medicine for asthma and COPD, type 2 diabetes, antiplatelet/anticoagulant therapy, or hypertension. Medicines reviews could also be offered if a significant adherence issue became apparent during the dispensing of a prescription. NHS remuneration was available for pharmacies with accredited staff to recruit up to 400 eligible patients to MURs per year. There was no annual quota for NMS consultations. Payment for these was based on the number of consultations in relation to the number of prescription items dispensed.^{4,5}

There has been limited empirical investigation of the outcomes or patients' perspectives of these services.⁶ A randomised controlled trial of the NMS found self-reported medicines adherence increased by 10% after 10 weeks.⁷ Qualitative work within this trial found that the NMS was simplified and adapted in its implementation to fit with pharmacists' existing workloads.⁸ This and earlier qualitative investigations of MUR interactions highlighted quick 'tick-box' consultations, which comprised superficial checking and information giving, rather than patient-centred consultations. Medicines review practices were bounded by service delivery pressure and pharmacist concerns that patients may react negatively to advice.^{8 9} A study of patients' perspectives of the MUR reported that they found their reviews reassuring but had poor recall of the content of their consultation.¹⁰ There is little reference to alcohol in these studies.⁶

Alongside medication reviews, the delivery of a range of locally commissioned public health services, including sexual health screening, smoking cessation and alcohol interventions, is being encouraged in community pharmacy.¹¹ In addition, public health guidance advises health and social care staff generally to opportunistically carry out screening and brief interventions for hazardous and harmful drinking as an integral part of practice during the course of routine NHS contacts.² While community pharmacies are well placed to provide these services, the only randomised controlled trial of the

effectiveness of community pharmacy-delivered brief intervention for alcohol found no benefit,¹² and specific guidance for community pharmacists on precisely how to intervene to support health behaviour change is lacking.¹³ This paper, by exploring the experience of those eligible for medication reviews and who are likely to be classified as risky drinkers, suggests ways in which medicines reviews could be sensitive to patient preferences.

Method

Semi-structured interviews were used because they allowed for flexibility in data collection and the production of rich narratives which permitted analysis of how participants made sense of the topic under investigation.¹⁴ Patient advisors helped develop the topic guide and pilot the interview schedules. Community pharmacy is a commercial enterprise which variously uses the terms 'customer', 'client' and 'patient'. The term patient is used here after discussion with the patient advisory group because it is used in pharmacy training materials on medicines reviews.

Pharmacy and patient recruitment within pharmacies was pragmatic, aiming for a diverse sample of types of pharmacy and of people eligible for medication reviews who drank alcohol twice a week or more often, within the limitations of the field work time frame (March - April 2018). Patient advisors helped develop study recruitment materials. Patients willing to be interviewed were asked to confirm drinking status using the shortened form of the Alcohol Use Disorders Identification Test (AUDIT-C)¹⁵ and medication adherence using the five item Medication Adherence Report Scale (MARS).¹⁶ These tools were used to provide a level of screening for inclusion based on self-reported adherence and drinking. Neither are in routine use in UK medicines reviews. Pharmacist knowledge of patients' drinking or medication adherence is usually based on what patients disclose to them in conversation after they have been recruited to reviews.

Two researchers, a sociologist (MM) and an anthropologist (SM), conducted the field work. Interviews with patients were conducted in their own homes and were digitally recorded using the topic guide, which comprised open-ended prompt questions on use of medicines and alcohol in everyday life, use of the pharmacy, experience of medicines reviews and thoughts on talking about alcohol as part of a medicines review. A modified framework method was used to organise and present data from transcripts. This supported a constructionist thematic analysis which recognised the constitutive nature of language without focusing on micro level language use.^{17 18} NVivo 10 software was used for data management and coding. Some a-priori codes were established from the interview schedule but detailed coding was developed in analysis rather than predetermined. The stability and reproducibility of the coding was checked within the broader co-investigator team by comparing co-investigators' preliminary analysis of sample scripts with those of the main field researchers.

The study received research ethics approval (REC reference 17/YH/0406). All study participants were given verbal and written information explaining the study aims and their involvement. Written consent was obtained and participants were given assurances about the confidentiality and anonymity of their responses. Participants were free to withdraw from the study at any time. Participants received a £10 shopping voucher to thank them for their time. Participants in published data are anonymised and given identifier codes which convey some simple description. For example, INV-019-F-21-9 means that patient interviewee number 19 is female with a MARS score of 21 and an AUDIT-C score of 9. High MARS scores (on a scale of 5-25) indicate high levels of reported medicines

adherence. Higher AUDIT-C scores (on a scale of 0-12) indicate higher likelihood of a person's drinking affecting his/her health.

Results

Demographic data

Interviews were conducted with 25 patients (see Table 1) recruited from seven community pharmacies in three locations in the North of England; two suburbs of large towns with high levels of deprivation, another town with lower levels of deprivation and a nearby rural village with low levels of deprivation. The sample had little ethnic diversity. Following the categorization of pharmacy ownership used by Bush and colleagues,¹⁹ six were pharmacies from four large chains (more than 20 outlets but fewer than 200) and one was a small chain (20 outlets or fewer but more than 5). Some of the patients recruited through these pharmacies also reported on their experience of using large multiples (pharmacy chains with more than 100 outlets). Most patients were taking multiple prescribed medications and supplementary online or over the counter substances. A few were also using illegal drugs (see Table 2). One patient interviewed was taking just one prescribed medication (methadone). This interviewee does not feature in the discussion below because he was not a usual candidate for a medicines review, although taking high risk medication and drinking heavily every day.

Table 1. Characteristics of the interview sample (n=25)

Sex	9 women; 16 men
Age	Range 41-89 Mean=63
Higher Education	7 at undergraduate level
Employment	13 retired 1 semi-retired 8 sickness, disability or unemployment benefits 3 employed
Ethnicity	25 White British or Irish
Sexuality	25 Heterosexual
Partner status	16 married or partner 3 divorced 3 widowed 3 single
AUDIT-C Scale 0-12	Range: 3-12 Mean=8

MARS Scale 0-25	Range: 15-25 Mean=23.2
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Table 2. Self-reported medication and other drug use (n=25)

Prescribed medications per person	Range: 1-16 Mean=6.6
Prescribed opioid substitution therapy	2
Taking self-prescribed supplements	14
Self-prescribed supplements per person	Range: 1-6 Mean=2
Using illegal drugs	3

Patients' general experience of being asked about alcohol in health settings

Most patients interviewed had some experience of being asked about their alcohol consumption by a range of health professionals. Although this included pharmacists, more usually the inquiries came from GPs, nurses, dentists, hospital consultants and others. Some had been asked multiple times:

They nearly always ask me. Even when I went for my blood tests and whatnot the nurse asked...(INV-002-M-25-6).

The inquiry was usually about their alcohol consumption in terms of units:

...it was just a question and answer. How much do you drink and how many units, that sort of thing. (INV-006-F-25-10).

Some found it difficult to connect their drinking with the unit measures referred to:

On the odd occasion in the GP's surgery ...he'll ask questions, how much do you drink. I can't answer in terms of numbers of units of alcohol, I can't think in that way... I can't equate ... the government's language...to my personal ... circumstances... I can't translate that. (INV-021-M-24-7).

Some interviewees said they gave details of how much they drank without receiving feedback: "I presume if they thought it was bad, they would give me advice" (INV-009-F-25-8). Others expressed concern about receiving feedback that might tell them to stop drinking:

I think you do need a bit of feedback but I was kind of hoping they wouldn't, because I know what the answer is really I suppose. Don't do it. (INV-006-F-25-10).

In terms of receiving interventions, 4/25 interviewees had received treatment for drug and/or

alcohol dependence, and nine more mentioned consultations of varying lengths with a health professional where they had been advised they should reduce drinking.

Patient expectations of pharmacists

Interviewees displayed different levels of awareness of the pharmacist's role and expertise. Some viewed the pharmacist as a basic supplier of medicines:

I think people just think of them [pharmacists] as dishing them [medications] out from the cupboard. (INV-013-F-22-3).

Others viewed them as health professionals with high levels of training in a specific area. One interviewee had changed their view of the pharmacist role after receiving some useful information about a medication she had been given when abroad on holiday:

... that's when I realised that pharmacists know more than I would have before given them credit for. They're not just dolling out the tablets...they've got such a lot of knowledge about the interaction of other drugs with drugs. (INV-020-F-23-9).

Some people highlighted an ongoing relationship with staff in the pharmacy, while others described an impersonal service. A few were wary of the pharmacy as a profit motivated business that might sell things to them that were not always useful or effective, while others had experiences which countered this suspicion, for example being advised that cheaper generic supplements were as good as branded ones. Those with experience of services like flu vaccination were aware that pharmacists were providing 'advanced' services.²⁰ Whatever their view of the pharmacist's role, most interviewees said it was the GP to whom they would first take their medication concerns. Some appreciated the pharmacist as a supportive backup to the GP.

Patient experiences of medicines reviews

Interviewees were unfamiliar with the terms 'medicines use review', 'new medicine service' and their acronyms. 18 of the 25 had been invited for a chat about their medicines in a private consultation room in a pharmacy or had received telephone calls from a pharmacist to ask how they were getting on with a new medicine. Most people said they liked the interaction but their recall about what had happened was generally poor. A few said they found their review tangibly useful because they had learned something new about their condition or medication which they followed up. Only one woman who had very recently had a MUR recalled the experience clearly. She described the review as a "consultation" and also as a "survey", "...to make sure I knew what I was doing with my medicines and did I need any advice" (INV-017-F-24-11).

Most interviewees said that they found their medicines review reassuring, it confirmed that they were doing the right thing and they appreciated someone taking an interest:

...it gives you more confidence that you're taking things correctly, even if you are fully already confident ... not everyone reads all the packaging and [it's important to] make sure they know what they're doing. (INV-005-M-25-11).

Some interviewees mentioned concerns and questions about their medication in the interviews which they said they had not raised in any of their consultations with a health professional. Some also said they had not told the truth about how they actually took their medication because they

expected the pharmacist to just tell them to follow the prescriber's instructions and they had their own reasons for not wanting to do so:

I told a lie. I says, yes, I take some during the morning and some at night. I didn't say I took them all in the morning...Because she wouldn't have agreed with me, she'd have tried to persuade me to do it the proper way... so long as they were working, I thought ... I'm taking them [my way]. But I suppose really that's her job to have told me you're not doing it right. (INV-024-M-21-6).

Patient experiences of alcohol discussion in medicine reviews

Four of the 18 interviewees who had received a medicines review recalled being asked about alcohol as part of it. Two interviewees with AUDIT-C scores of 11 and 6 recalled being asked a question about consumption (INV-014-M-22-11; INV-002-M-25-06), one interviewee with an AUDIT-C score of 11 recalled being told about unit limits (017-F-24-11) and two people with AUDIT-C scores of 11 recalled being told to "drink less" (INV-014-M-22-11), or avoid drinking to "excess" (017-F-24-11).

An ex-publican (AUDIT-C score 11) who was taking medication for arthritis, fibromyalgia, high blood pressure, allergies and stomach acid was attending his pharmacy for blood pressure checks as part of a pilot scheme. He and another interviewee at the same pharmacy did not distinguish between their medicines reviews and the other chats they had with the pharmacist or pharmacy technician at their blood pressure checks. Their pharmacist regularly suggested that they drink less. This interviewee recalled:

And he tells me in the side room, and he says [name], you've got to drink less... So many units...He's got the chart up there. He'll say [name], you drink too much...When my blood pressure's high he says you're still drinking, aren't you? I said yeah. And I said you have a pint, don't you? So, he said well... Not a lot though, not like you. I said well, I might as well lie down and die if I can't have four pints a night...because it's boring. I couldn't sit there... watching television. (INV-014-M-22-11).

This interviewee said he had reduced his drinking from previous much higher levels after hospitalisation for alcohol-related damage to the oesophagus and was now feeling no immediate ill effects.

A woman (AUDIT-C score 11) who used inhalers, hay fever medication, antidepressants and had taken a series of courses of antibiotics for periductal mastitis said that alcohol had been raised by the pharmacist in her MUR because he could smell smoke on her. He asked her about this in relation to her asthma and this led on to alcohol:

And then he asked me, you know, do you drink a lot? Do you go out on the weekend and maybe drink quite a bit in one evening and stuff? And I said, no, not really. I'm not a pub goer. I'll have a few glasses at home and that's it...So he said, well do you know what happens with alcohol and your medications and checked that I knew what I was doing and that it isn't recommended to drink. ... it was great that he took an interest, that he was trying to help me. Giving me advice and telling me that, you know, it's not recommended you drink with your medicines. And I said, I know that....I mean I didn't realise how many units I was consuming. I don't think most people do....it made me think I need to cut it down and get back to just having it on a Friday and Saturday, rather than like the last three weeks, every night. (INV-017-F-24-11).

In her interview she expressed a number of alcohol and medication related concerns that she had not brought to the review. These included worries about the effects of taking long term medication on her efforts to have a child, her use of alcohol to cope with stress and to help with sleep and previous experience of unpleasant interactions between an antidepressant and alcohol.

Warnings about specific interactions were reported by some of the interviewees in the pharmacy when they collected their medicines, outside of the framework of a review. An interviewee with an AUDIT-C score of 11 who had been treated for alcohol dependence and was taking multiple medications recalled being told he smelled “like a brewery” when he collected a new medicine from a pharmacy (INV-018-M-23-11). The pharmacist advised him that he could drink on the medicine but that he should cut down.

Appropriateness of alcohol as a subject for discussion with pharmacists in medication reviews

23 of the 25 interviewees said that they were open to the idea of having a discussion about alcohol as part of a medication review with a pharmacist. Two were explicitly not open to such a discussion. One of these with an AUDIT-C score of 10 said drinking was his “only release” given the increasing severity of his illness which now confined him to the house (INV-012-M-23-10). This interviewee was taking multiple medications, including morphine patches for severe chronic pain, and did not want anyone telling him to stop drinking:

If I want a drink, I’m over 21 and I want a drink...I don’t want to stop drinking. (INV-012-M-23-10).

Neither of these interviewees had received a medicines review nor wished to have one, and neither had a relationship with the pharmacist at the pharmacies they used and viewed it more as a shop than a healthcare setting. They said it would be a personal matter for their doctors if they had an alcohol problem. For the 23 interviewees open to the idea of a discussion about alcohol as part of a medicines review, acceptability was dependent on the conversation being routinely provided to all patients, confidential, well-conducted and relevant.

Interviewees did not want to feel singled out in a stigmatising way. They wanted to know the subject was coming and was being raised routinely with everyone:

I think that to include alcohol, if you do it for everyone, then it’s going to become more normal. (INV-015-M-24-05).

Some were concerned about being called on to talk about it too frequently:

I don't mind, as long as it's not...they're not on at you all the time... Like if you get new medication or maybe just a review every so often, that's fine. (INV-019-F-21-9).

Asking routinely in a linked discussion about medications made the subject of alcohol seem appropriate in the pharmacy setting:

... sounds entirely reasonable. Okay, we drink alcohol because it’s a social thing to do and because we enjoy it. But on the other hand I think that most people know that alcohol is a drug and, okay, it’s not the same [as other] drug[s]...[but] alcohol, even in small quantities, could be counter-active to the medication you’re on. And ... in that scenario it’s entirely reasonable to discuss it, so there’s nothing wrong in that (INV-015-M-24-5).

Some people, women in particular, strongly welcomed the opportunity to get more information. Some of these felt they already knew the 'rules' but not enough about why the 'rules' were there. Others were not sure about how drinking limits related to their own particular medicines and conditions:

It would be useful for me right now... I need to double check that the medication I'm currently on, should I be thinking about when I take it, does it have an interaction with alcohol ... to my knowledge, I've not had that information, and maybe I should seek it...(INV-020-F-23-9).

There was a strong level of agreement that any such conversation be non-judgemental and made personally relevant:

I'd expect information rather than a judgement...as soon as anybody feels they're being judged, they'll walk away. (INV-020-F-23-9).

Some people said that it was a good idea because pharmacists had more time than doctors. Others, however, doubted that pharmacists had the time or the communication skills:

The pharmacy is busy you know and I don't know whether they ... unless they have got dedicated people, I don't think really, they have got all that much time to sit and chat and tell people all about it because I don't think you can limit how much time you are going to talk to somebody because [it] depends on how involved they want to get. (INV-011-M-24-5).

An ongoing relationship with the same pharmacist was an important proviso for some interviewees:

To me, if you're going to talk to somebody it's going to be some[one] that's maybe going to be there regularly ...If you were seeing the same person, well, you... build trust up with somebody... [not] just one that drops in every so often ... (INV-003-M-24-8).

For others, trust in the pharmacist as a professional bound by confidentiality was important:

No, I wouldn't [mind talking about alcohol] because they have a duty of care and a duty of confidentiality. They'd get drummed out of their professional association if they broke those rules. (INV-21-M-24-7).

Doubting relevance: having a long term health condition but not a 'problem' with alcohol

Around half of the interviewees said that they were happy to talk about alcohol because they thought they did not have a problem. This idea of openness with a pharmacist because of having 'nothing to hide' came up in 12 of the 25 interviews. Two interviewees with AUDIT-C scores of 11 said that while they were happy to discuss their drinking with a pharmacist, this would not make any difference to their own drinking:

I don't mind. They could talk to me [until] black's blue and I'll just say I like to go out for my pint at night. (INV-014-M-22-11).

Many interviewees with AUDIT-C scores ranging between 5 and 10, which indicated risky or hazardous drinking, described themselves as "casual", "social" or "moderate" drinkers. Even though

all interviewees were drinking at levels that involved some risk, approximately half did not identify an alcohol and medicines discussion as personally relevant to them.

Twelve people, all with long term health conditions, said that it was acceptable for a pharmacist to ask about alcohol as part of a medicines review but they did not think the alcohol element of the discussion was of particular relevance to them because they did not have a drinking problem:

Good idea... [but] at the moment to be quite honest I don't think there's any problem. I mean you know yourself if there was a problem... if I was drinking a bottle a day, something daft like that, fair enough. (INV-003-M-24-8).

The idea of the discussion of alcohol is viewed in such comments as being appropriate for others with clear problems with alcohol. These interviewees had scores of 6 and 8 on the AUDIT-C. Neither interviewee spoke of potential hazards to health outside of alcohol dependence. Alcohol was not considered a factor in their daily health management, which included taking medications for blood pressure, prostate problems, epilepsy and gastric problems. Similar comments were made by other interviewees:

I suppose because I consider my alcohol intake to be pretty moderate, not a problem, you know, if I go without a drink for a week, it doesn't...well, I might say I could do with a beer but, you know, I'm not off down the offy or anything. (INV-022-M-24-7).

This interviewee had an AUDIT-C score of 7 and took medication to control blood pressure and cholesterol. He described himself as a “regular” rather than “heavy” drinker. He spoke about not liking taking medication and had made changes to his diet and exercise, but did not consider alcohol in that same sense. He thought a discussion about alcohol and medicines would be more appropriate for those with more “serious” conditions:

I can understand someone who probably has, I don't know, a more life threatening condition, shall I say, than mine, and maybe because of that they might have some problems with alcohol as well, and I can understand how that all fixes together and causes some real problems. So in general, I can see why that might be useful, but personally it's not. (INV-022-M-24-7).

While some people with long term health conditions said raising the subject was of more relevance to their idea of the ‘problem drinker’, an interviewee who self-defined as an alcoholic and had an AUDIT-C score of 11 said he thought it would be more useful for people with long term health conditions:

... other people haven't got that same diagnosis [alcoholism]. They've got long term health problems, nonetheless...and I think talking to a pharmacist would probably be good. (INV-007-M-15-11).

Discussion

The people above were taking multiple medicines for long term conditions, sometimes from different prescribers, for which they reported high levels of adherence, and a range of self-prescribed supplements. As in other studies of medicines reviews, the advice given by pharmacists was generally perceived by patients interviewed as reinforcing prescriber rules.^{10 21} Research on lay understanding of medicines finds that patients conduct their own individualised risk assessments. These are conducted because patients understand their medicines not only as positive therapeutic

agents but also as potential sources of risk, particularly side effects, and as a potential threat to autonomy.^{22 23}

Some patients spoke about being inhibited in their reporting of both medicines and alcohol use in reviews with pharmacists if they felt they might be perceived as doing something wrong. Some were concerned that discussing alcohol with pharmacists meant being judged or told not to drink. Many struggled to translate the healthcare advice they had already received about alcohol limits into meaningful personal terms. Advice thought to lack relevance or considered judgemental was unwelcome.

Except for warnings of acute interaction, alcohol was predominantly seen in terms of dependence. Some interviewee concerns were based on particular conceptions of alcoholism and its social stigma. The unease at the potentially moralising dimension of alcohol discussion seen here reflected the findings of Tam and colleagues, in which alcohol enquiry in an Australian General Practice context was perceived by some patients as implying that they have a drinking problem.²⁴ Rather than seeing alcohol on a continuum of risk involving considerations of the possible consequences of taking doses of a psychoactive neurotoxin in combination with medicines and other substances for conditions and symptoms over time, thinking about alcohol harm was largely dichotomised, with an assumed majority of low consumption drinkers (the norm) and a minority of problematic drinkers. Inquiries about alcohol use were often experienced as referring to dependence rather than about wider long term health issues. Characterisations of interviewees own drinking as “moderate” and its synonyms were subjective and varied and did not consistently correspond with the risks indicated by interviewees’ AUDIT-C scores.

Pre-existing ideas about the nature of alcohol problems therefore had an important bearing on how patients conceived the idea of discussing alcohol as part of medicines reviews. As noted by others,²⁵ almost all patient interviewees were positive about the basic idea of an alcohol and medicine linked discussion with a pharmacist. This openness was contingent on the discussion being made relevant to them by linking it to their condition and their medication, similar to prior GP findings.²⁴ Personal relevance, however, was regarded partly through the prism of a particular set of ideas about the nature of alcoholism and therefore in common with the findings of Quirk et al., some judged the possibility as not relevant to them because they did not see their drinking as a ‘problem’ in these terms.²⁶

Those most in favour of the idea of introducing alcohol into medicines reviews said that they were aware of the basic alcohol guidance and medications ‘rules’ and wanted to better understand how they might apply to their own health. There was general agreement that any such conversation with a pharmacist should be well-conducted, non-judgemental and ideally form part of a joined up approach rather than a duplication of services.

This is a qualitative study and as such makes no claims for generalisability but aims to provide a level of detail and transparency to allow the reader to determine the extent of potential transferability of findings to other contexts. The study was designed to elicit patients’ views and experiences of talking about alcohol with pharmacists in medicines reviews. While the sample size is sufficient to describe a range of views in a specific context, it lacks diversity in terms of ethnicity and sexual identity and includes fewer women than men. It is also notable that most of the patients in the sample, including heavier drinkers, reported high MARS scores although alcohol consumption has been associated with poorer medication adherence.^{27 28} However, the study yielded rich data, providing insights in the under-researched area of how patients experience and understand their alcohol use and how they might approach interactions with community pharmacists on the subject of alcohol and medicines. There is little in-depth qualitative work about patient experience of community pharmacy.^{29 6} A recent

descriptive focus group study of the experiences of a small group of patients in an area of high deprivation with experience of discussing alcohol consumption in a MUR at one pharmacy identified the importance of understanding alcohol advice within cultural contexts. While focus group members were open to discussions about alcohol with their pharmacist, they found official alcohol advice confusing and difficult to implement in everyday work and leisure settings which facilitated consumption.²⁹

This paper raises important issues about whether and how patients may be open to engaging in a discussion about alcohol with a pharmacist in a medicines review. The patients' understandings of the pharmacist's role, their relationship with the pharmacist, and their previous experiences of alcohol discussions are likely to play a part in how the prospect of discussing alcohol with a pharmacist is regarded. The ways in which pharmacists approach alcohol in medicine review services may be improved by a better understanding of how patients conceptualise alcohol and 'problem drinking'. Patients in this study and in a study in a GP setting²⁴ expressed a clear preference for alcohol discussion to be made more relevant by linking alcohol directly to their condition(s) and medications.

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1. Burton R, Henn C, Lavoie D, et al. A rapid evidence review of the effectiveness and cost-effectiveness of alcohol control policies: an English perspective. *Lancet*. 2017;389(10078):1558-1580.
2. The National Institute for Health and Care Excellence (NICE). *Alcohol-use disorders: prevention (Public health guideline PH24)*. 2010.
3. NHS Digital. Statistics on Alcohol, England, 2017. <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/statistics-on-alcohol-england-2017>. Accessed 08/08/2018, 2018.
4. PSNC. MURs: the basics 2018; <https://psnc.org.uk/services-commissioning/advanced-services/murs/murs-the-basics/>.
5. PSNC. New Medicine Service (NMS). 2018; <https://psnc.org.uk/services-commissioning/advanced-services/nms/>.
6. Stewart D, Whittlesea C, Dhital R, Newbould L, McCambridge J. Community pharmacist led medication reviews in the UK: Scoping review of the Medicines Use Review and the New Medicines Service literatures. *Research in Social and Administrative Pharmacy*. Submitted.
7. Elliott RA, Boyd MJ, Salema NE, et al. Supporting adherence for people starting a new medication for a long-term condition through community pharmacies: a pragmatic randomised controlled trial of the New Medicine Service. *BMJ Qual Saf*. 2016;25(10):747-758.
8. Latif A, Waring J, Watmough D, et al. Examination of England's New Medicine Service (NMS) of complex health care interventions in community pharmacy. *Res Social Adm Pharm*. 2016;12(6):966-989.
9. Latif A, Pollock K, Boardman HF. The contribution of the Medicines Use Review (MUR) consultation to counseling practice in community pharmacies. *Patient Educ Couns*. 2011;83(3):336-344.
10. Latif A, Boardman HF, Pollock K. Understanding the patient perspective of the English community pharmacy Medicines Use Review (MUR). *Res Social Adm Pharm*. 2013;9(6):949-957.
11. NHS England. *NHS: Five year forward view*. NHS;2014.
12. Dhital R, Norman I, Whittlesea C, McCambridge J. Effectiveness of alcohol brief intervention delivered by community pharmacists: study protocol of a two-arm randomised controlled trial. *BMC Public Health*. 2013;13:152.
13. Brown TJ, Todd A, O'Malley C, et al. Community pharmacy-delivered interventions for public health priorities: a systematic review of interventions for alcohol reduction, smoking cessation and weight management, including meta-analysis for smoking cessation. *BMJ Open*. 2016;6(2):e009828.
14. Pope C, Mays N. *Qualitative Research in Health Care 3rd Edition*. Oxford: Blackwell/BMJ; 2006.
15. Bradley KA, McDonell MB, Bush K, Kivlahan DR, Diehr P, Fihn SD. The AUDIT alcohol consumption questions: reliability, validity, and responsiveness to change in older male primary care patients. *Alcohol Clin Exp Res*. 1998;22(8):1842-1849.
16. Mahler C, Hermann K, Horne R, et al. Assessing reported adherence to pharmacological treatment recommendations. Translation and evaluation of the Medication Adherence Report Scale (MARS) in Germany. *J Eval Clin Pract*. 2010;16(3):574-579.
17. Gale NK, Heath G, Cameron E, Rashid S, Redwood S. Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *Bmc Med Res Methodol*. 2013;13.
18. Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006;3(2):77-101.

19. Bush J, Langley CA, Wilson KA. The corporatization of community pharmacy: implications for service provision, the public health function, and pharmacy's claims to professional status in the United Kingdom. *Res Social Adm Pharm.* 2009;5(4):305-318.
20. PSNC. Advanced Services. 2018; <https://psnc.org.uk/services-commissioning/advanced-services/>. Accessed 05/12/2018, 2018.
21. Latif A, Waring J, Watmough D, Boyd MJ, Elliott RA. "I expected just to walk in, get my tablets and then walk out': on framing new community pharmacy services in the English healthcare system. *Sociol Health Ill.* 2018;40(6):1019-1036.
22. Britten N. *Medicines and Society: Patients, Professionals and the Dominance of Pharmaceuticals*. Basingstoke: Palgrave Macmillan; 2008.
23. Rathbone AP, Todd A, Jamie K, Bonam M, Banks L, Husband AK. A systematic review and thematic synthesis of patients' experience of medicines adherence. *Res Social Adm Pharm.* 2017;13(3):403-439.
24. Tam C, Leong L, Zwar N, Hesse C. Alcohol enquiry by GPs - Understanding patients' perspectives: A qualitative study. *Australian Family Physician.* 2015;44(11):833-838.
25. Dhital R, Whittlesea CM, Norman IJ, Milligan P. Community pharmacy service users' views and perceptions of alcohol screening and brief intervention. *Drug Alcohol Rev.* 2010;29(6):596-602.
26. Quirk A, MacNeil V, Dhital R, Whittlesea C, Norman I, McCambridge J. Qualitative process study of community pharmacist brief alcohol intervention effectiveness trial: Can research participation effects explain a null finding? *Drug Alcohol Depend.* 2016;161:36-41.
27. Bryson C, Au D, Williams E, Kivlahan D, Bradley, K. Alcohol Screening Scores and Medication Nonadherence *Ann Intern Med.* 2008;149(11):795-803
28. Grodensky C, Golin C, Ochtera R, Turner B. Systematic review: effect of alcohol intake on adherence to outpatient medication regimens for chronic diseases. *J Stud Alcohol Drugs.* 2012 Nov;73(6):899-910).
29. Jamie K, Oliver EJ, Paterson A, Whittlesea C. Discussing alcohol in medicines use reviews: experiences of patients in a community pharmacy context. *Int J Pharm Pract.* 2018.