Missing in action: insights from an exploratory ethnographic observation study of alcohol in everyday UK community pharmacy practice

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Abstract

Introduction and Aims
This paper reports on an exploratory ethnographic observation study which aimed to understand how alcohol fits into routine service provision in the New Medicine Service (NMS), Medication Use Reviews (MUR) and pharmacists' everyday practices in UK community pharmacies.

Design and Methods
Observations were undertaken in five community pharmacies featuring nine community pharmacists. This involved observation of 16 MURs and 15 NMS consultations and informal interviews with pharmacists as they conducted their work. Fieldnotes were subjected to a constructionist thematic analysis.

Results
Pharmacists were underprepared and unconfident in discussing alcohol in medicine consultations. Most pharmacists raised alcohol consumption in the MUR and NMS as part of a 'lifestyle check'. They reported that alcohol was difficult to raise, and to discuss, and that people were reluctant to talk about their drinking. Their main concern was that raising the topic would alienate customers.

Discussion and Conclusions
These findings raise questions regarding a range of issues about how pharmacists discuss alcohol in medicines consultations, why they lack a clear sense of purpose in doing so and therefore where alcohol fits into UK community pharmacy practice.

Key words 6 (US spelling)
Community pharmacy, medicines review, alcohol, lifestyle, qualitative research

Word count: (**4202)**

Introduction

Alcohol is a psychoactive drug which presents a major public health challenge [1]. It causes more than 200 diseases and injuries, and drinking alcohol at any level poses a risk to health [2]. Alcohol is the third leading cause of ill-health in the UK [3] and reducing alcohol consumption is a key public health priority. Community pharmacy is seen as having a potential role in reducing alcohol consumption.

Community pharmacies are private businesses contracted by the National Health Service to provide local pharmaceutical services outside of the hospital setting. In the past, interventions to reduce harmful alcohol consumption rarely featured in community pharmacy [4]. More recently, because of its large workforce and wide population reach, community pharmacy has been called on to expand its public health and clinical roles [5, 6].

Changes in commissioning frameworks are providing increasing scope for alcohol interventions. 18% of community pharmacies have adopted, or are adopting the Healthy Living Pharmacies (HLP) framework, in which non-pharmacist members of staff are trained as 'health champions'. There is as yet, limited data on the provision or outcomes of any alcohol services offered under this framework [5, 7]. A 2016 systematic review of UK community pharmacy-delivered interventions for public health priorities found insufficient evidence to evaluate community pharmacy-delivered interventions for alcohol reduction [8]. The only randomised controlled trial of an alcohol brief intervention within the community pharmacy setting found no evidence of effectiveness [9].

The NHS Community Pharmacy Contractual Framework (CPCF) introduced the Medicines Use Review (MUR) in 2005 [10] and the New Medicines Service **(NMS)** in 2011 [11] as 'advanced' services. These are short confidential reviews of medicines use with a pharmacist which aim to improve patients' medication adherence, improve understanding and also reduce avoidable medicines waste [12, 13]. A private consultation room is a contractual requirement for these services, and 90% of UK community pharmacies now have one [14]. MURs are one-off consultations conducted face to face whereas the NMS is delivered in three stages, the last two of which can be conducted by telephone. Pharmacists are required to complete a self-assessment based on the national competency framework before providing these services. In order to submit claims for payment, they are required to capture and retain a dataset for each review undertaken [12, 13].

Although medicine use is the key focus of both the MUR and NMS, new MUR and NMS guidance, from 2012 and 2013 respectively, suggests pharmacists provide some form of "healthy living advice" during the consultations [15, 16]. The MUR guidance states that pharmacists can chose to advise on alcohol, smoking, physical activity, nutrition, weight management, and/or sexual health, without instruction on what this advice should entail [15]. In England, people aged 55-64 are the age group most likely to be drinking at hazardous levels: **recent survey evidence shows 41% of men and 24% of women aged 55-64 drinking over 14 units in a usual week [17]**. Many of these are likely to be eligible for medicine reviews on the basis of long-term conditions and taking new or multiple medications. The authors are not aware of any **other** specific guidance given for MURs and NMS on how to raise alcohol and what to do if patients are drinking at risky levels.

Despite most UK pharmacies conducting hundreds of MUR and NMS consultations per year, (4,327,3018 were conducted 2007/8 - 2017/18 [18]), there are only two observational studies of how these services are performed in practice [19-23]. As Latif's observational data on the delivery of MURs was collected prior to 2012 when the MUR lifestyle advice requirement was introduced, even less is known about how alcohol fits into these services in practice [19]. Nothing about alcohol is reported in the study exploring the implementation of the NMS [24]. UK surveys exploring community pharmacists' views on discussing alcohol more broadly, found low levels of alcohol-specific knowledge, lack of confidence and variability in brief intervention skills [25, 26]. This paper reports on data from a small, exploratory ethnographic observation study conducted as part of the intervention development phase of a 5 year research programme (Community pharmacy: Highlighting Alcohol use in Medication aPpointments; CHAMP-1). The aim was to explore how community pharmacists deliver MUR and NMS services in their everyday environment to see whether and how conversations about alcohol consumption feature in the MUR, NMS, or elsewhere in the pharmacy in everyday practice.

Method

Pharmacy recruitment took place between February and April 2018 and pragmatically sought diverse types of pharmacies in the North of England (see Table 1). Following the categorization of pharmacy ownership used by Bush and colleagues [27], four of the five pharmacies were large chains and one was a small chain. Pharmacies were selected in neighbourhoods with different levels of relative deprivation as measured in the English Index of Multiple Deprivation [28].

Two researchers, an anthropologist and a medical sociologist (SM and MM) conducted 10 half day ethnographic observations (40 hours in total), systematically recording observable phenomena inaccessible by any other method [29]. Similar to the work of Latif and colleagues, a standardised observation template (Table S1, Supplementary Information) was used to guide observations, thus ensuring data were focused and efficiently gathered [12]. The fieldworkers adopted the 'observer-as-participant' role [30], conducting opportunistic informal interviews with pharmacists prior to, and following, consultations. The data are thus understood as constructed through interactions between the pharmacists and researchers whose interest in alcohol was transparent. Contemporaneous field notes were taken by each researcher and transcribed shortly after leaving the pharmacy, with narrative description expanded upon. Separate analytic notes were made during transcription to begin to identify themes. The interview data comprised observations and accounts of practice which helped to understand how the pharmacists constructed the "lived experience" of their practices [29]. Nvivo 10 software was used (by MM and SM) to organise the data and substantive analysis was thematic: *a priori* codes from the template were used and other codes were inductively derived through co-authors' readings of the data. Themes reported here relate to the patterning of observations of alcohol discussion in the dataset. Findings were also discussed with the programme's multi-disciplinary research and advisory teams, including pharmacists and patients.

Community pharmacy is a commercial business which variously uses the terms 'customer', 'client' and 'patient'. The potential problematic uses of the term 'patient' have been widely debated [31]. After discussion with the programme patient and public involvement group, 'patient' is used here because it is currently used in pharmacy training materials on medicines reviews and because of the absence of a suitable alternative which captures the particular responsibilities and vulnerabilities inherent in medicine and alcohol discussions with a health care professional.

The study received UK Health Research Authority 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.

Results

Eight fully qualified pharmacists (five men and three women) and one pre-registration pharmacist (a woman) at five pharmacies were observed and opportunistically interviewed. Data were collected for six pharmacists on length of service (mean 12.3 years; median 10.5 years) and years qualified (mean 23.3 years; median 18.5 years). Length of service data were not collected for the pre-registration and two relief pharmacists. Observations included 16 MURs conducted by seven pharmacists with an average duration of 10 minutes and 15 NMS conducted by four pharmacists with an average duration of four minutes. Two of the NMS were conducted by a pre-registration pharmacist and these have been excluded from the analysis below because of the practitioner's trainee status.

All of the MURs observed were face-to-face consultations conducted in a private consultation room. These MUR consultations mainly involved working rapidly through a list of the patients' medications, checking their knowledge of what each was for, and inquiring about medicines routines, side effects or problems. One observed NMS was a face-to-face conversation in the consultation room initiated by a patient who asked to speak to the pharmacist about potential side effects of a new medication. At the end of this conversation, the pharmacist asked the patient about the best time to conduct a follow-up telephone call (as is usual in NMS service delivery). Consultation rooms in four of the five pharmacies were small spaces adapted for use. The other room was designed for consultations and was larger and brighter. The smallest room was described by the pharmacist as an "add on" and "not really fit for purpose" (OBS-007). All but one of the rooms had doors from the shop floor and the dispensing area and all contained a computer, a bench or desk and two or three chairs.

Twelve of the 13 included NMS observed were conducted on the telephone and focused on the pharmacist's side of a short, usually three to four minute, conversation (there were also many observed attempts to contact people without success). Two involved discussion of the patient's medicine having being changed by their GP since their first NMS consultation. These conversations differed from the other 10 in which the pharmacist quickly checked how people were taking their medicines, whether the medicine was working for them and whether they were experiencing side effects. There was some discontinuity in the

conversation for patients in a couple of cases when the pharmacist conducting a follow-up call was not the same one who had explained the new medicine in the first consultation.

Alcohol in MURs and NMS consultations

Alcohol was mentioned in 13 out of 16 MURs and five out of 13 NMS. It was discussed in a little more detail in two of these 13 MURs and one of these five NMS. Where alcohol was mentioned, it tended to form part of a short "lifestyle" section that "tags on" to the end of the consultation alongside smoking, diet and exercise questions (OBS-010). Pharmacists used phrases such as, "okay, there's a couple of lifestyle questions" and "okay, I just want to check a few other things" to move from a medicines-focused discussion to a separate lifestyle section. This section usually comprised a series of questions and statements, as in the following example from an MUR:

> Pharmacist: Few other health related things…
> [Smoking and diet mentioned]…
> Pharmacist: Physical activity?
> Patient: I do plenty of walking.
> Pharmacist: 20 minutes? Research suggest 20 minutes of walking a day is good for your heart.
> Patient: I'm always rushing about. Can't sit still.
> Pharmacist: Alcohol?
> Patient: Tot of brandy
> Pharmacist: At night before bed?
> Patient: Yeah, brandy and coke.
> Pharmacist: I'll send a note to the GP. While I get that sorted out for you. Anything else? (OBS-005)

A question-answer pattern was established in such exchanges with little elucidation or exploration of the answers given. Most pharmacists inquired about alcohol intake, then quickly moved on. In some interactions, recommended levels of consumption were mentioned or the pharmacist suggested that people should "keep it [alcohol intake] moderate" (OBS-010). One pharmacist's reported view of their own practice confirmed most of the observations:

> I just ask, 'how much do you drink?' Get the information and then move on to the next thing. (OBS-006)

In some cases (6 NMS and 1 MUR conducted by 4 different pharmacists) generic 'lifestyle' was linked to the patient's condition. For example, one pharmacist asked a patient in an NMS who had suffered a stroke: "Have they [the GP] been through healthy lifestyle advice to try to reduce your risk factors?" (OBS-010). The pharmacist then continued with a series of 'lifestyle' questions and statements about exercise and diet which did not include alcohol in this instance. This pharmacist at a large chain explained that she always asked about lifestyle issues in a MUR or NMS because she had to tick the boxes on the computer system

to complete the report and lodge a financial claim (OBS-010). However, not all forms of lifestyle advice had to be given, hence alcohol was not raised on all occasions (OBS-010).

In the one NMS and two MURs where alcohol was discussed in more detail, the focus remained on telling patients the recommended units and/or advising the patient to reduce consumption. The pharmacist in the NMS discussed alcohol in connection with the patient's blood pressure:

> So obviously with it being high blood pressure, have they gone through healthy lifestyle with you? […patient response inaudible]
> OK, so do you know what recommended levels are? […]
> 14 units for men and women now […]
> So be honest with the doctor when you discuss that then […]
> Well not to some people but others may be […]
> We always say try not to drink two consecutive days in a row […]
> So you're having more at the weekend but it's going over the limit […]
> It is something to think of, it does play a part in your health […]
> Not saying give up altogether […]
> If you want leaflets, we've got them in here. (OBS-010)

Alcohol is a drug that contributes to high blood pressure, which is then often treated by another drug to reduce blood pressure [32]. This pharmacist advised the person in the consultation that alcohol had a part to play in their health. They did not, however, explain the specific implications of alcohol in the context of the medication the person was taking for their condition, which was the core focus of the review. The pharmacist instead focused on checking out the person's understanding of general recommendations about levels of alcohol consumption, advised them to report their drinking to their doctor honestly and recommended that they think about the advice "we always say" to not drink on consecutive days. This advice on alcohol consumption was then followed by reassurance that the pharmacist was not saying, "give up altogether" (OBS-010).

In one of the MURs where alcohol was discussed further, the pharmacist asked about alcohol intake and the discussion unfolded as follows:

> Patient: Oh it's too much
> Pharmacist: What do you think too much is?
> Patient: We have two alcohol free days per week
> Pharmacist: Do you know about units?
> Patient: I'm aware I have too much, we have a bottle of wine with a meal [Pharmacist enquires a bit more]
> Patient: It is always around food and more red wine than white.
> Pharmacist: Are you ok and happy with this?
> Patient: Yes, I'm fully aware but I enjoy eating and drinking too much.
> Pharmacist: I mean you can drink but units shouldn't be more than 14.
> Patient: I know it is but I don't do it.
> Pharmacist: Well that's fine, your medication isn't interacting because you are taking it in the morning with breakfast and you keep active so that's

good. (OBS-001)

As in the NMS above, the focus of the discussion included attention to recommended limits, with the person articulating awareness of exceeding them, and a lack of inclination to change. This person was taking aspirin, medication for cholesterol and high blood pressure and yet the potential impact of alcohol on blood pressure and as a gastric irritant was not explored. The pharmacist instead said there were no issues with any acute medication interactions, thus reinforcing what the person had said.

In the other MUR where alcohol was discussed, the patient disclosed that he drank "ten pints per week" spread over three different days. The pharmacist replied:

Pharmacist: We all like a drink…Any problems mixing with your meds? With alcohol you need to be careful with it.
Patient: [non-committal]
Pharmacist: There are NHS targets. As long as you are sensible…being reasonable, being sensible. Anything you want to ask? (OBS-008)

Here the pharmacist attempted to normalise drinking, advised being "sensible" and asked the patient whether he had experienced any problems mixing alcohol with his medications. In answer, the patient subsequently raised stomach issues but the possible impact of alcohol was not explored. Instead, later in the conversation the pharmacist offered advice for stomach issues, which included the possibility of consuming alcohol:

Pharmacist: I personally think peppermint tea after meals helps digestion and relaxes muscles your stomach is made from. In Mediterranean countries some people drink an aperitif, digestif infused with herbs.
Patient: I just have Rennies or Gaviscon. (OBS-008)

After the consultation, the pharmacist explained:

> If there is a risk from alcohol with the drug they are on, I ask about how much they drink and to beware the mix… I listen to them to mitigate anything that might kill the kidney or damage the liver. (OBS-008)

In the observed MUR and NMS consultations, alcohol was rarely raised or discussed in connection with the patient's medicines or long term conditions. Pharmacists suggested moderation using a variety of terms, including "being sensible", or searched for acute individual medication-alcohol interactions**.** In our view, this practice served to legitimise the lack of further consideration of drinking and its possible impact on health if there were no interactions.

Pharmacist concerns about raising alcohol

All of the pharmacists said alcohol was "difficult" to raise with patients, although two said that they would rather talk about alcohol than sexual health. One pharmacist said he used "banter" to help his patients feel "relaxed" (OBS-008). One pharmacist at a small chain said

that he would not usually raise the subject in his MURs at all; although he recognised the issue as important, he was concerned that asking his customers, "how much do you drink then?" would "alienate" them (OBS-007). Some pharmacists reported patients closing down, being "in denial" (OBS-001) or under-reporting their drinking: "no-one ever tells me they drink over the recommended amounts" (OBS-006). When patients did open up about their drinking, some pharmacists appeared unclear about how to respond. In the second MUR detailed above, where the patient said he drank "10 pints per week", the pharmacist reflected on his practice by saying:

> Yes, I couldn't think if that [10 pints] was OK! What should be my reaction? Do you drink bitter or lager? Am I meeting Public Health England standards? I don't know. (OBS-008)

Some, like this pharmacist, expressed uncertainty regarding giving alcohol advice. Others gave qualified advice. For example, after the one NMS consultation detailed above, the pharmacist explained that the patient had asked her whether she agreed that it was impossible for most people to remain within the limits of the recommended units on holiday. She said she replied, "not to some people but others maybe". On reflection, the pharmacist explained her equivocal response:

> I don't want to appear judgemental; but also don't want to condone it…we find it difficult to discuss. (OBS-010)

Many of the other pharmacists were wary of asking people about alcohol because of a worry that it implied they were making a negative judgement of their customer: "we are not here to be the police anyway" (OBS-001).

Alcohol elsewhere in the pharmacy

One pharmacist said alcohol was, "in my mind in the MUR," but was not routinely discussed elsewhere (OBS-010). She explained, "we don't have time to raise it" and "people are here for medicine and it might be a weird thing to ask about" (OBS-010). However, some pharmacists were observed and reported responding to patient's questions about alcohol, the most common being, "can I drink with this?" (OBS-006). The pharmacist who reported rarely raising alcohol in MURs was observed responding to a patient who asked about drinking with a medicine. He advised the patient not to drink during, and for two days after, the course of medication and explained the rationale for the advice to the patient:

> Pharmacist: [because] after a five-seven day course, it builds up in your system.
> Patient: I knew you would know.
> Pharmacist: I always tell people to avoid alcohol but I've known some people who have drunk and had no problem. (OBS-011)

This advice given was thus followed by a qualifier that some people have not come to harm by not following such advice. Another pharmacist had experiences of raising the subject of alcohol outside of medicines reviews as part of a public health campaign. Despite the

incentive of a £10 voucher the pharmacist found that people were, “so unhappy to talk about alcohol…. we had to ask a lot of questions and people were not open to talking about [it]” (OBS-001).

Discussion

Study findings emphasise the cursory nature of the alcohol consumption check as part of a ‘lifestyle’ section in medication reviews and the wider uncertainties about the place of alcohol in UK community pharmacy practice. These extend the observational study data of Latif et al. [19] and Morton et al.’s interview study on lifestyle discussions in MURs and NMS services [33]. Raising alcohol within this ‘lifestyle section’ was rarely followed by any exploration of the implications. Pharmacists collected basic consumption information and/or spoke about “moderate” or “sensible” drinking without mobilising such ideas in exploratory ways. The handling of alcohol advice in discussions in our dataset was at times ambiguous, and at other times qualified, including warnings of acute alcohol-medicine interactions, which also occurred outside of MURs. The pharmacists appeared mostly not to be confident of the place of alcohol in their practice. Findings are in keeping with other UK studies which highlight lack of confidence and report pharmacists providing little advice on alcohol use [25, 34]. **This is perhaps unsurprising given the limited MUR and NMS guidance regarding advising on alcohol.** Only one pharmacist in our study reported having any specific training on alcohol beyond a general awareness of recommended limits, which may explain why these pharmacists lacked the confidence to provide advice.

The data echo findings in some previous studies of audio and video recorded routine GP-patient consultations in New Zealand and the USA that included mentions of or discussions about alcohol [35, 36]. Moriarty et al. found GPs presenting signs of discomfort, asking closed polarised questions, using mitigated or non-specific advice and changing the topic quickly to defuse any perceived tensions [36]. Denvir’s analysis suggested that GPs may not probe patient answers about alcohol consumption in order to maintain rapport and respect patients subjective understandings of their own drinking [35]. The pharmacists in this study used similar practices to avoid breaching perceived social norms and giving offence, a concern that has been raised by pharmacists elsewhere [34]. The concern is that asking about drinking might be taken as an implied accusation of drinking too much.

The rationales given for these approaches taken by pharmacists are rooted in the sensitive nature of alcohol discussions and the conceptual baggage that surrounds and moralises discussions of alcohol. When GPs raise alcohol in consultations with patients, both parties’ personal lives and motivations, and notions of morality regarding alcohol, can affect the subsequent discussions [37, 38]. Primary care practitioners other than pharmacists have been shown to have concerns about damaging relationships with patients in conducting alcohol brief interventions. [39, 40] For pharmacists, the risks were similar and the seeming alternative within a largely binary construction of right or wrong alcohol consumption was to “condone” or legitimise patients’ drinking (OBS-010). For one pharmacist, the possible threat alcohol discussions posed to maintenance of good relationships with customers meant avoiding raising the topic altogether.

A sister study in the CHAMP-1 programme found that, despite its social sensitivity, most 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 [41]. Unhealthy drinking should be expected to complicate existing health problems, so effective alcohol interventions may generate wider health benefits [42]. Discussing alcohol in the context of medication appointments may provide a useful opportunity to consider its health implications. However, this study indicates that pharmacists are currently underprepared to tackle the subject.

In light of findings from this study and its sister study [41], the CHAMP-1 programme has developed and will test a training intervention for pharmacists that aims to improve communication skills, confidence, role legitimacy and knowledge of alcohol related health risks for those taking medications long term.

To the authors' knowledge, this is the first study to explore how alcohol fits into MURs and NMS by observing them as they happen. The study was small and exploratory in nature, with a limited number of pharmacies and consultations observed in the North of England. It was intensive rather than extensive, generating rich insights that would need further testing in other contexts for transferability. The study was conducted with pharmacists open to the study aims. It is possible therefore that some of the discussion of alcohol observed was an artefact of pharmacists' awareness that they were being observed by researchers with an interest in the subject. It is also notable how little attention was paid to alcohol nevertheless. Note-taking of observations of interactions is inevitably less detailed than recordings of interactions but was detailed enough to capture the content of alcohol discussions.

Our findings raise further lines of enquiry as they suggest that the ways in which alcohol is routinely raised in NMS and MURs are unhelpful in facilitating meaningful discussions. Difficulties in discussing alcohol appear to apply to pharmacists as well as patients [9, 43]. Given the challenging nature of the topic, **and the limited guidance provided,** pharmacists found their own skilfully non-committal and friendly ways to navigate the uncertainties caused by a lack of clear sense of purpose in relation to alcohol and their practice.

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Conflicts of Interest

The authors have no conflicts of interest.

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