Beer, Wine, Whiskey and Patients: Simple, Helpful Clinical Talk

Introduction

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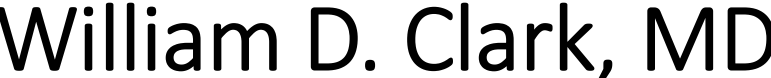

- Founding member and Fellow of the ACH - President 2005
- Retired from his clinical career as an internist and addiction medicine specialist in 2004
- Director of the medicine residency at the Cambridge Hospital, Medical Director of addictions programs in Massachusetts and Maine
- Epidemic Intelligence service officer
- Publications include papers and chapters about physician-patient relationship and communication, alcohol problems and physician self-awareness
- Lecturer in Medicine at Harvard Medical School
- Co-author of DocCom module 29 - Alcohol: Interviewing and Advising

Get Active about Alcohol - Compassionately

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- Caring for people who drink too much is a “behavior change” situation requiring respectful, relationship-centered recommending, reflecting, negotiating and summarizing. Too many clinicians avoid (or bungle) conversations that could assist their patients avoid much suffering.
- Summary of this talk, and the “take-homes”
  - Recall that “safe,” “normal,” or “moderate” drinking can be problematic
  - Know criteria for “At risk” drinking and “Alcohol Use Disorder”
  - Use verified screening and assessment tools
  - Learn about “Brief Intervention,” and learn to make succinct recommendations and respond reflectively and empathically to whatever patients say.
  - Negotiate agreement on plans
    - Refrain from persuading and arguing - both verbally and non-verbally – patients will “check out” and cease listening/ participating

Alcohol

- Affects every aspect of medical care
  - “A little” alcohol may cause problems like accidents, medication screw-ups, unintended pregnancy, friendship or marital problems;
  - “A lot” causes a multitude of problems in thinking, action, emotional life, and a lengthy catalog of incapacitating and deadly alcohol-induced biological problems.
- Serious problems- called *Alcohol Use Disorder*- afflict 20% adults at some time in their life
- Counseling improves patient health & clinician satisfaction
- Definitive “diagnosis” is often elusive, and may not be necessary in order to be of service and assistance to patients
- However, established and **published criteria** provide clarity about the nature of problems and **systematic assessment** provides patient data- together they improve clinicians’ ability to assist patients in changing harmful behaviors

“Safe” Alcohol Use

- >50% of US adults abstain (or drink less than one drink monthly)
- **Standard drinks**
  - A “drink” is 12 oz. beer (~5% ethyl alcohol), 5 oz. wine (~12%), 2-3 oz. of cordial/ aperitif (~20%) or 1.5 oz. whiskey (~40%); a ”drink” is thus ~ 0.6 oz. of ethanol
- People modulate drinking according to internal states like pleasure, shame or hangover, and to external feedback like reprimands, criticism and sanctions
- **“ Safe drinking” = drinking at or below NIAAA “Safe Limits”**
  - “Safe limits:” men, 14 or fewer drinks a week, **and** no more than 4 drinks in a day; women and anyone over age 65, 7 per week **and** 3 drinks in a day
  - Also called “moderate drinking”
    - (“Social drinking” is a term in common use, without clear definition of amount or consequences, and **not helpful** in clinical settings)

“At Risk” Alcohol Use

- Failure to consistently modulate produces “At Risk” drinking or “Alcohol Use Disorder - AUD” (AUD definition later)
- **“At Risk” drinking =** Drinking more than “safe limits.” Called “at risk” because it is likely to produce biological, social or psychological harm
  - (Diagnostic and Statistical Manual of Mental Disorders, DSM-5 - Am Psychiatric Assoc. 2013)
  - 30% of US adults drink more than “safe limits”
- “At Risk” drinking can produce:
  - Medical problems: GI; Cardio-V; hematologic; neuro; cancers; psychological and
  - “Hazardous” situations: chainsaw, driving, pregnancy, medications

“Alcohol Use Disorder” (AUD)

- A “maladaptive drinking pattern that causes life problems” (Diagnostic and Statistical Manual of Mental Disorders, DSM-5 - Am Psychiatric Assoc. 2013)
- People with AUD drink above safe limits, and it is the resulting **problems** that define AUD, not the **quantity** of intake
  - AUD lifetime prevalence in U.S. = 29% & 12-month prevalence = 14%
- AUD is an inability to consistently control one’s drinking
  - Typically, when asked about drinking, drinker makes excuses, blames others and show hostility; drinker selects friends / partners who overlook intoxication & social, family and other consequences

- (“Alcoholism” is used loosely, usually refers to persons with AUD of unspecified severity. Not helpful in clinical conversations)

AUD is a *brain disorder*

- AUD derives from an Interaction of psychology and physiology that disrupts brain neurotransmitter systems and their functions, most notably GABA(A) receptors and the dopamine system. These disruptions…
  - …create a biologic urge to drink more (“feels good”)
  - …facilitate neurologic “tolerance” (drinking a lot without signs of intoxication)
  - …produce cognitive problems and memory deficits (at times, “blackouts” hours or days long)
- **AND**…when very steady heavy drinkers stop, “unmasking” the brain’s excitatory state, withdrawal symptoms ensue, often with serious morbidity, even death

Always Ask About Drinking

- Ask,“Do you sometimes drink beer, wine, or other alcoholic beverages?”
    - Patient responds with “no,” you can leave the topic
    - Patient responds with “yes”, follow up with the "single item alcohol screen…"
- …Ask men under 65 this “single item alcohol screen” for men:
    - "How many times in the past year have you had 5 or more drinks in a day?"
- …Ask women (and men over 65) the “single item screen” for women and elders:
    - "How many times in the past year have you had 4 or more drinks in a day?"
- If response is “one time” (or more); this means they are an “at risk” drinker
- If response is "never," you can move to another topic
- (Don’t ask open-ended questions: “Tell me about your alcohol use.”
    - Most patients respond with vague answers and this forces clinicians to ask clarifying questions that erode trust and safety, because patients feel accused of lying)

- Screen all who drink, because people who drink a lot minimize their intake
  - Many studies: **60 – 80%** of cases are missed w/o formal screening
- Screen with 3 Q from the 10-Q AUDIT; score each Q 0-4 as indicated
  - How often do you have a drink containing alcohol? (0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily
  - How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2, (1) 3 or 4, (2) 5 or 6, (3) 7 to 9, (4) 10 or more
  - How often do you have five or more drinks on one occasion? (0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily
- Score 4 = “at risk” (sensitivity of 73-86%, and a specificity of 89-91%)
- Score >4, use the full 10-Q AUDIT to make a full assessment

Assessment – the 10-Question AUDIT

- Patients can self-administer AUDIT,, or ancillary staff can help as needed

1. How often do you have a drink containing alcohol? (0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily
2. How many drinks containing alcohol do you have on a typical day when you are drinking? (0) 1 or 2, (1) 3 or 4, (2) 5 or 6, (3) 7 to 9, (4) 10 or more
3. How often do you have five or more drinks on one occasion? (0) Never, (1) Less than monthly, (2) Monthly, (3) Weekly, (4) Daily or almost daily

How often during the last year have you…

4. …found that you were not able to stop drinking once you had started? (0) Never, (1) Less than monthly, (2) Monthly (3) Weekly, (4) Daily or almost daily
5. …failed to do what was normally expected from you because of drinking? (0) Never, (1) Less than monthly, (2) Monthly (3) Weekly, (4) Daily or almost daily
6. …needed a first drink in the morning to get yourself going after a heavy drinking session? (0) Never, (1) Less than monthly, (2) Monthly (3) Weekly, (4) Daily or almost daily
7. …had a feeling of guilt or remorse after drinking? (0) Never, (1) Less than monthly, (2) Monthly (3) Weekly, (4) Daily or almost daily
8. …been unable to remember what happened the night before because you had been drinking? (0) Never, (1) Less than monthly, (2) Monthly (3) Weekly, (4) Daily or almost daily
9. Have you or someone else been injured as a result of your drinking? (0) No, (2) Yes, but not in the last year, (4) Yes, during the last year
10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down? (0) No, (2) Yes, but not in the last year, (4) Yes, during the last year

- AUDIT scores: >4 and <13 (women) or <15 (men) suggests **at risk drinking** only;
- >/= 13 (women) or 15 (men) **usually means AUD** (with or without physical dependence)

After AUDIT assessment:

- A "Brief Intervention" with focus on cutting down or quitting is effective for "at risk" drinkers
  - This 5-10 minute intervention can be accomplished in the office or at a hospital bedside
- For drinkers who have AUD…
  - …conduct a 5-10' brief intervention whose focus is referral to an addiction specialist
  - …at return visits, listen reflectively and repeat a similar brief intervention, but refrain from trying to do more intensive counseling
  - …few clinicians who are not addiction specialists have the time or skills to do so

- Brief Intervention (BI) increases the likelihood of successful outcome, whether the patient is "At Risk," or is AUD
- Every clinician should be able to do BI, in office or hospital
- General aspects of any BI:
  - Above all, create a welcoming and empathic climate conducive to dialogue
  - State recommendations clearly, slowly and succinctly; pause….
    - Leave space for patients to respond *(close mouth, open ears)*
    - Respond to their responses with reflective and/or empathic statements, <u>before</u> returning to recommendations/planning
  - Remain supportive and compassionate throughout
  - Persuading, reasoning, arguing, etc. NEVER advance the conversation, usually hinder progress

Brief Intervention specifics

- >75% of people with AUD express interest in change; readiness to take action correlates positively with severity
- "Preface" for your recommendation:
  - Example A-(based on patient disclosure/ AUDIT:) "Your weekend drinking is above safe limits that NIAAA and other experts advise, and I'm worried…
  - Example B- (includes medical data:) "Your (blood tests, broken leg, big liver, etc) show that alcohol is hurting your health, and I'm worried…
- The recommendation: "…I recommend that we work out a plan for you to cut back to safe limits, or to stop alcohol entirely. What do you think about this?"
- Listen reflectively, and do not argue, because conversations that do not provoke resistance often prepare patients for an action decision at a later time
  - Don't force patients into "all or nothing" situations ("if you don't quit, you'll die," etc.)
- Express optimism and offer options

Brief Intervention - Patients who agree to take some action

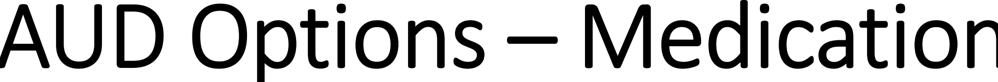
- Help set a specific goal (cut down or abstain.) “We share the goal of improving your health, then. Do you have a next step in mind?”
  - If “cut down” is the choice, work out details and agree on a plan that includes specific action steps, such as a way to record use, strategies for managing high-risk situations and people who might help
  - If “quit” is the choice, agree on a plan that includes specific action steps, such as strategies for managing high-risk situations and people who might help
- Provide NIAAA handouts (download from website)
- See patients at feasible short intervals, and at follow-up, support and encourage them and renegotiate goals and strategies as needed

Brief Intervention –Patients who don't agree to discuss change

- Restate your **concern**: "As I said, I'm concerned for your health-that's a job I take very seriously." (then, encourage reflection)
- "I wonder if you would be willing to think out loud about the pros and cons of drinking and of cutting down or quitting, for a few moments, now or at another visit?"
- Restate your **willingness to help**. "Whatever you decide, I'm on your side, and I've had experience with plenty of other folks who have been in this kind of situation."

For those with AUD, show further concern if appropriate…

- Show concern by saying something like, "As you consider our conversation, and if you decide to make a change in the future, please know that I will help with any or all of the following:" *(without persuasion!!)*
  - Medications that we know can be helpful (neurobiological)
  - Referral to Professional counseling that we know can be helpful (psychological)
  - Referral to Mutual help groups that we know can be helpful (social)



AUD Options – Medication

- Patient discussion – AUD is similar to other chronic illnesses like diabetes; AUD has behavioral, environmental and genetic roots and a firm decision and "will power" help, but cannot be the full solution any more than they can be for diabetes.
- 4 medications approved & effective
  - Naltrexone
  - Acamprosate
  - Disulfiram
  - Extended-release injectable naltrexone
- You might say, "Research and experience show that certain medications can help people who are coping with alcohol problems. If you would consider this option, we can discuss the pros and cons; and work out a system that would help you succeed. What do you think?"
- Medications include counseling

AUD Option - Referral

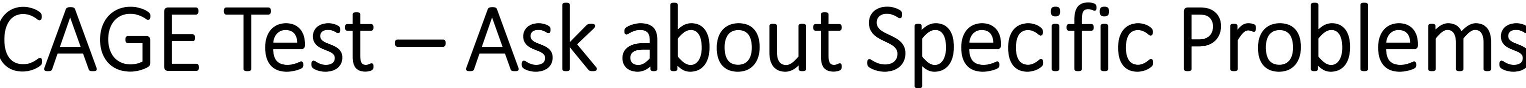
- Engage behavioral health specialists: social workers, substance use counselors or psychologists
- You might say,
  - “The addiction resource center on Spring Street has helped many of my patients and hundreds of others. Before you leave we will help you make an appointment there so that you can check out the possibilities.”
- You might refer to a mutual help group, saying something like,
  - "Most people find that talking with people in Alcoholics Anonymous is helpful. AA might or might not be right for you. I recommend you go there and see what you think. Many of my patients have been surprised and helped."

Conclusion

- Learn as much as possible about patients' drinking, because it influences every aspect of medical care
- Alcohol makes thinking difficult; physiologically, psychologically, socially
- Assess with structured screening and assessment tools
  - Use relationship-centered dialogue - persistence diminishes suffering
- With At Risk drinkers, use "Brief Intervention" (5-10 minutes of counseling)
  - Make a definite recommendation & listen to patients' perspectives
  - Show compassion & make empathic statements at appropriate moments
- With AUD drinkers, recommend referral, medication and mutual help
- Give At Risk & AUD patients the downloadable NIAAA treatment pamphlet

Express Compassion & Receive Gratitude

- Remain compassionate as you face AUD patients' suffering, although they tend to stifle caring instincts
- Help patients see their own perspectives by exploring their ideas about pros and cons of changing
  - Explorations build a sense of autonomy, optimism and confidence that help trigger change
- Create a nonjudgmental climate, giving information in a "scientific" way
  - Use numbers and scores from rating scales, etc. to encourage discussion
- Use fact-based language:
  - "Three of your liver tests are abnormal," instead of "alcohol has damaged your liver"
  - "Your alcohol level in Emergency was .160," instead of "You were drinking heavily before you came in"
  - "You mentioned 3 important things, -- that your relationship with your wife is going poorly, that you are having stomach trouble and that you lost your driver's license;" instead of "Alcohol is wrecking your marriage, your career and your body."
- Present information in an impersonal way; such as the following:
  - "Research shows that treatment helps"
  - "Having a high tolerance for alcohol means that a person is deprived of the early warning system that tells them to stop before they get to a dangerous level"
  - "Becoming sick in the morning until after a drink generally means a person's brain has become hooked on alcohol"
- Avoid conveying, "I know what is right for you." This provokes resistance that begins an enervating downward conversation spiral, demoralizing everyone and assuring poor adherence.
- Patients will be grateful for your compassionately expressed concern, your expertise and your clarity



CAGE Test – Ask about Specific Problems

1. Have you ever felt that you should cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye opener)

Ask specific AUD problems:

- "Driving Under the Influence" (DUI)
- Job loss or relationship, family or marriage difficulties
- Dependence symptoms - tolerance and withdrawal
- Organizes most life activities around alcohol

More Information

Includes a Facilitator Guide for Faculty

Evidence-Based Importance of Communication Skills

- Improve medical outcomes
- Decrease malpractice claims
- Enhance physician/provider satisfaction
- Improve patient satisfaction scores
  - HCAHPS surveys mandated by the government if hospital receives Medicare funds from the government
  - Analysis demonstrates that 2 communication dimensions drive scores

DocCom Overview

- Module authors - leading faculty
- 42 multimedia-rich interactive on-line modules (~1 hr in length)
- > 40 CME/MOC credits
- >400 videos realistic interviews (loved by learners)
- Annotated interactive videos
- Faculty Resources
  - Assignments
  - Assessment questions – essay & MCQs
  - Grading matrix
  - Resources
  - Curriculum guides for faculty.

Sample Module

- Consistent format across modules
- Rationale
- Key concepts
- Learning goals
- Content
- Videos interspersed
- Behavior checklist
- References

MODULE 33 WELCOME
- Rationale
- Patient's View
- Doctor's View
- Questions
- Key Concepts
- Learning goals

INTRODUCTION

6 STEPS: NEWS & SUPPORT
- Advance Planning
- What is known?
- What want to know?
- Sharing information
- Respond to emotions
- Plan and follow up

SPECIFIC TOPICS
- Clinician self reflection
- Family won't tell
- Language barriers
- Telling a prognosis
- Phone notifying of death
- Saying I'm sorry
- Hopes and wishes

VIDEO: You have cancer

VIDEO: Treatment fails

CONCLUSION

BEHAVIOR CHECKLIST

REFERENCES

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This demo version does neither contain assessment questions nor allows facilitation of learing groups by the sophisticated DocCom Learning Manage System. If you're interested in DocCom, please see http://aachonline.org for a trial

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Welcome to DocCom DEMO Module 33:
"Delivering Bad News"

D., Carly Dennis M.D., Anthony Caprio M.D., Catherine Gracey M.D.

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Facilitator Guide of this module for DocCom Residency Doctoring Curriculum

Credits:

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Video Assoc. Director:	Dennis Novack M.D.
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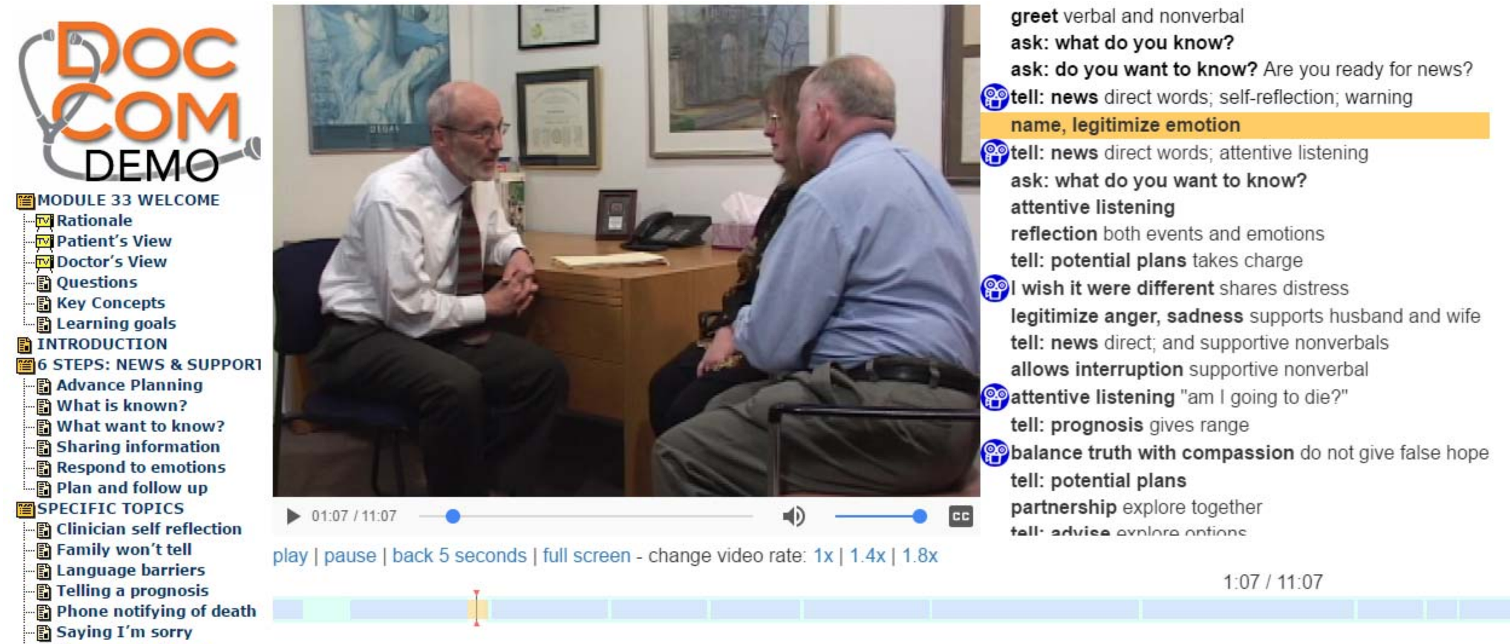
DEMO Module 33: **Delivery of Bad News** - by Timothy Quill MD, Anthony Caprio MD, Catherine Gracey MD, Margaret Seaver MD

Annotated Video Examples



Empathy Understanding

Hello, Christof Daetwyler 1 ASSIGNMENT MY PROFILE GRADING RESOURCES Survey / Log Out / Help

DOC COM

- MODULE 6 WELCOME
  - Rationale
  - Patient's View
  - Doctor's View
  - Questions
  - Key Concepts
  - Learning goals
- INTRODUCTION
- RELATIONSHIP SKILLS
  - Attentiveness
  - Empathy
  - Respect
  - Support
  - Partnership
- WATCH BEHAVIORS
- TEST UNDERSTANDING
- BEHAVIOR CHECKLIST
- References
- CME INFORMATION
- ASSESSMENT QUESTIONS

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06 2 MediocreBuildRelationship

1:05 / 3:39

play | pause | back 5 seconds

Please click the pink button "missed opportunity for empathic comment" whenever Dr. Bird does not act on opportunities to provide empathic comments. You may submit a free video comment where you demonstrate how to do a better job (use mobile device to capture/upload directly)!

missed opportunity for empathic comment (6: ✓✓✓✓_ _)

special buttons:

write your comment here and click button below to place it at current time

add a free-text comment

add a video comment

#	✓	✗	not found	score %	score n
1	6	0	0	100%	24
actual	4	0	2	67%	16

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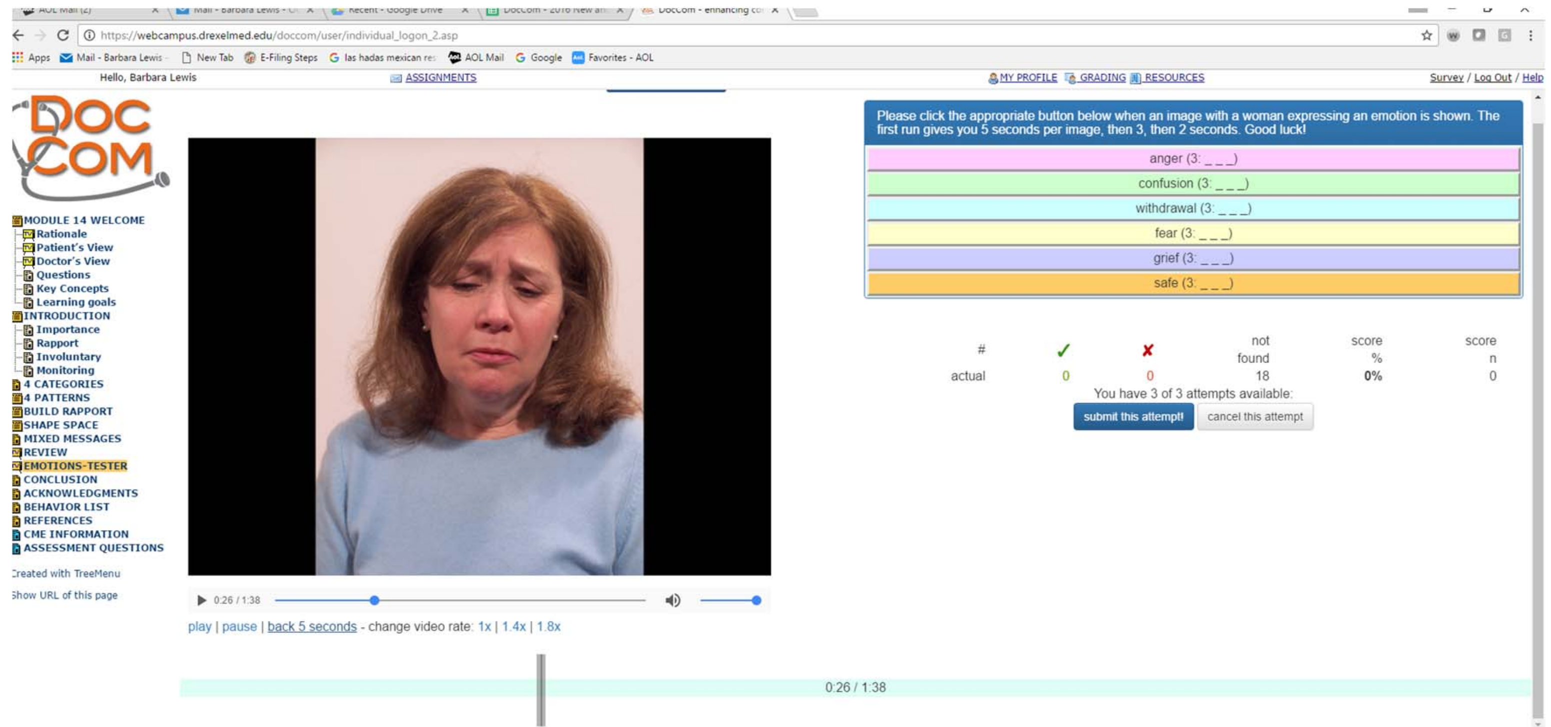
06: **Build the Relationship** - by Julian Bird MD and Steven Cole MD

Facial Recognition



Resources

Advanced Communication Topics
Facilitation Guide

Series of 12 One-Hour Learning Sessions

Facilitator Guide

FACILITATOR NOTES

Session 2: Personal Attitudes Toward Illness, Vulnerability and Death
Practicing the HPI

Date: *Tuesday 9/17 & Thursday 9/19*
Time: *2:00 – 4:00 PM*
Location: *Queen Lane Seminar Rooms (SPs during the second hour)*

Objectives:

1. Explore feelings and thoughts in relation to beginning dissection.
2. Expand understanding of how personal attitudes toward illness, vulnerability and death might affect patient care.
3. Review the elements of the opening of an interview and eliciting an HPI.
4. Understand using facilitation skills to elicit a patient's history.
5. Understand the importance and techniques of eliciting patient concerns, beliefs, fears and hidden agendas.
6. Understand what is meant by professionalism and how this session promotes self-reflection as a necessary and healthy habit for professional development.

DocCom Assignment: **Module 08** Gather Information
Read the module. No need to complete multiple-choice or discussion questions

Reading and Writing Assignment: **Read**: Coulehan, J., Cadaver Stories, Medical Encounter, 14-18. (1994 Fall) and Melinda Moniz: Honorable Name. Also, please read the definition on Professionalism.

Write: A brief piece that expresses your reactions to beginning dissection. This can be a creative piece – a story or poem, or simply your feelings and thoughts. Describe how your awareness of your own feelings and thoughts relates to your professional development as defined in the ABIM definition professionalism. Bring this with you to the session and be prepared to share with your group members.

Discussion: (60 minutes) Clinical Framework Issues:

- Further thoughts from last session.
- Reactions to dissecting a cadaver and sharing of written reflections.

Standardized Patient Small Group Exercise: (45 minutes)

- Practice the skills of eliciting an HPI with a standardized patient.
- Include attention to the use of facilitation skills, especially attentive silence, and eliciting the patient's concerns.

Wrap-up: (15 minutes) What did we learn today? Topics for next session.

Personal Awareness: Topics for Reflection What were your apprehensions about dissection? Did the "Cadaver Stories" reflect how you felt when beginning your dissection? Has the prospect of, or experience with dissection, caused you to reflect on your own attitudes about death and dying? How do you feel dissecting a cadaver will influence your attitudes toward death and dying, and your abilities to work with patients with these issues? (Some feel that dissection is the first step in physicians' increasing familiarity with death, which may lead to becoming distant or insensitive in dealing with the issues of death and dying.) How might your personal experiences with loss and grief affect your ability to work with dying patients? If you were dying, what do you think you would want and need from your physician?

6

Syllabi

Admin ***Guide***

Admin Guide

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