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

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- Director of the medicine residency at the Cambridge Hospital, Medical Director of addictions programs in Massachusetts and Maine
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- Publications include papers and chapters about physician-patient relationship and communication, alcohol problems and physician self-awareness
- Lecturer in Medicine at Harvard Medical School
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Get Active about Alcohol - Compassionately

• 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

• 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

4. How often during the last year have you…
   ...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
BI Counseling: Communication Principles

• 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, *before* 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
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  – Curriculum guides for faculty.
Sample Module

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

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

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Facilitator Guide for this module for DocCom Residency Showing Medicine

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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

greet verbal and nonverbal
ask: what do you know?
ask: do you want to know? Are you ready for news?
tell: news direct words, self-reflection, warning
name, legitimize emotion
tell: news direct words, attentive listening
ask: what do you want to know?
attentive listening
reflection both events and emotions
tell: potential plans takes charge
I wish it were different shares distress
legitimize anger, sadness supports husband and wife
tell: news direct, and supportive nonverbal
allows interruption supportive nonverbal
attentive listening “am I going to die?”
tell: prognosis gives range
balance truth with compassion do not give false hope
tell: potential plans
partnership explore together
tell: service continuing
Empathy Understanding
Facial Recognition
Resources

Advanced Communication Topics

Facilitation Guide

Series of 12 One-Hour Learning Sessions

Facilitator Guide

Syllabi

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