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General practitioners' dual role in expert assessments of harmful alcohol use and fitness to drive – a qualitative study

ORIGINAL ARTICLE

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Background and aim

Harmful alcohol use can be a sensitive topic, and discussions with patients about alcohol can be challenging. In some cases, alcohol use can result in patients being deemed unfit to drive. The main aim of this study was to explore general practitioners' experiences with their dual role as clinician and expert assessor in relation to patients' alcohol use.

Material and method

This is a qualitative study in which general practitioners attending a seminar on changing alcohol habits in general practice were invited to participate. Audio recordings from group discussions in four seminar sessions were transcribed and analysed using systematic text condensation.

Results

The general practitioners (N = 36) reported that the dual role of clinician and expert assessor can be challenging when assessing medical fitness to drive in patients with possible or confirmed harmful alcohol use. Several found the regulatory framework governing fitness to drive unclear and difficult to interpret, with the use of discretion within both a clinical and legal framework being particularly challenging. However, some found the regulation to be useful in supporting behavioural change in relation to alcohol.

Interpretation

General practitioners experienced a challenging dual role as clinician and expert assessor in the efforts related to alcohol use. It is unclear to what extent the current driving licence regulation and associated guide improve health care and contribute to road safety.

Main findings

General practitioners in this study found the dual role of clinician and expert challenging when assessing alcohol-related fitness to drive under Norway's driving licence regulation.

Several considered the regulatory provisions on alcohol to be unclear.

Some doctors reported that the risk of being deemed unfit to drive due to high alcohol consumption could facilitate therapeutic work on changing drinking behaviour.

Alcohol is a legal intoxicating substance used by a large proportion of the adult population (1). For most people, alcohol consumption is associated with social contexts and positive experiences (2). However, alcohol can cause, trigger and exacerbate a range of conditions, including cancer (3), cardiovascular disease (4), liver disease (5), dementia (6), diabetes (7), injuries (8) and mental disorders (9). The Norwegian Directorate of Health's fitness to drive guide provides information on the practical application of medical fitness to drive criteria (10). It also describes what is required to regain fitness to drive status *after* a patient has been deemed unfit to drive. Where there is doubt about a patient's fitness to drive, doctors may impose a temporary driving ban pending clarification (10).

General practitioners (GPs), in particular, can find themselves in a difficult position in relation to patients' alcohol consumption (11, 12). Assessing alcohol use and signs of increased risk or harm, followed by the offer of further information or follow-up (alcohol screening and brief intervention), may have a beneficial effect on alcohol consumption (13). Such interventions are well supported by the general population (14). However, patients with risky or harmful drinking may react negatively (14), and healthcare personnel may encounter barriers at both the individual and system level (15–17). Patients may also fear potential implications for their fitness to drive status (12, 18). Assessing possible road safety risks related to alcohol problems is difficult (19), and balancing the patient's need for autonomy with society's need for safety can be challenging for doctors in relation to fitness to drive assessments (20).

The PEth test (phosphatidylethanol) is a marker of alcohol consumption in the 2–4 weeks prior to blood sampling (21). The test has high sensitivity and specificity, but there is considerable individual variation. Gamma-GT and ferritin are still used as biomarkers of high alcohol consumption, including when doctors find it difficult to address drinking habits with patients and initiate PEth testing (22, 23).

The main aim of this study was to explore GPs' experiences with their different roles in relation to patients' alcohol use, as both a clinician and an expert in fitness to drive assessments.

Material and method

GPs from four medical practices in Stavanger and Oslo were invited to take part in a study on alcohol and health in general practice. One component of the study was a seminar on alcohol-related health problems in general practice. The seminar consisted of four sessions at each practice between February 2020 and May 2021.

The first author invited GPs from medical practices with at least five GPs to participate in the seminar (16). The instructors were the first author, a psychologist, a patient representative, a counsellor and specialists in substance use and addiction medicine, all with extensive clinical, personal and/or academic experience in the field. Each session lasted 3–4 hours and covered evidence linking alcohol and common health problems (24), as well as training in motivational interviewing (25). Ample time was allocated for discussion on initiating conversations about alcohol, based on participants' own experiences and case vignettes.

The study data consisted of audio recordings of participants' discussions during the seminar sessions. The topics discussed in the first three sessions were the relationship between alcohol use and health and ageing, how to initiate conversations about alcohol, and the use of communication techniques and other tools. The final session addressed collaboration with other services, patient experiences, addictive medications and alcohol, as well as ethical and practical challenges related to alcohol use and fitness to drive. The first author led the discussions.

The recordings were transcribed verbatim and analysed using four-step systematic text condensation (26). Each author read the transcripts and organised the content into preliminary themes (first step). The authors then discussed these themes and identified and coded/grouped meaning units relevant to the research question (second step). The meaning units within each code were then condensed (third step). In the fourth step, these were reworked (recontextualised) into an analytical text addressing the research questions. Participants were given fictitious names.

The study was approved by the Regional Committee for Medical and Health Research Ethics (REK 6848 (2019/1112)) and by the data protection officer at Stavanger University Hospital (8/2020). Written informed consent was obtained to record the discussions and use them in research. The study was funded by the Center for Alcohol and Drug Research, Western Norway Regional Health Authority (KORFOR) and a research grant from the Rogaland Medical Association, Allforsk.

Results

A total of 36 GPs consented to participate. Three of the medical practices were privately owned, and one was run by the local authority. Table 1 summarises demographic data for the 24 GPs who attended at least three of the seminar sessions.

Clinician or 'police'?

Several participants described the distinction between clinician and expert assessor as the most challenging aspect of work concerning patients' alcohol use. While recognising the need to discuss alcohol in consultations about illness, they were also concerned that patients might avoid seeking care or raising the issue for fear of being deemed unfit to drive due to their alcohol consumption. In such cases, the doctor would lose an opportunity to provide appropriate health care. 'Espen' described the following:

'We often find ourselves in situations where we are expected to act as expert assessors, such as in fitness to drive cases, while at the same time being on the patient's side. I've been threatened with legal action in the past year, and I'm regularly reported to the County Governor. In such situations we never really move forward with the medical issues, because the person is so angry about the driving licence issue. It's very damaging to the doctor–patient relationship and the work we are supposed to do.'

Several GPs who found their role as expert assessor as a barrier to discussing alcohol-related problems were concerned about the potential implications for patients' health. Even clinical records could be shaped by fitness to drive considerations, as 'Eva' noted:

'I've had patients asking whether it is possible not to document things in their medical record. This prevents people from seeking help. There can be a lot of focus on the risk of being deemed unfit to drive. The result is that many live with serious problems for too long and are afraid to seek help.'

Several GPs had experienced that the trust and cooperation between them and the patient were weakened after they notified the authorities that a patient was deemed medically unfit to drive due to harmful alcohol use. This could trigger strong emotions over a long period and, in the worst case, lead to a permanent breakdown in trust. The process of regaining fitness to drive status through documentation of abstinence could also be lengthy and challenging. 'Harald' described it as follows:

'[The previous GP submitted] a notification to the County Governor due to intermittent harmful alcohol use. This led to such a serious breakdown of trust between the patient and the GP that the patient could not continue there. In my case, it involved years of PEth testing to regain the fitness to drive status [permanently]. Each time the patient came in, we had to spend a long time discussing what had happened with the previous GP and how difficult this was.'

The challenging regulation

Several GPs found the legislation difficult to fully comprehend and insufficiently precise. They were uncertain which aspects and consequences of alcohol consumption they were supposed to assess: was it the immediate intoxicating effect, or the longer-term implications for the patient's health? 'Trond' described it as follows:

'Are we supposed to assess the likelihood of the patient driving after consuming alcohol? Or should we focus on the impact of drinking a certain amount of alcohol on their general health? If it's solely the general health aspect, we should have some standardised tests, as we do for older patients with cognitive impairment.'

Several GPs found the assessment of alcohol-related health impairment particularly challenging. Many felt that the Norwegian Directorate of Health's fitness to drive guide was too vague and provided insufficient guidance for assessing medical fitness to drive. Several called for clearer and more explicit criteria for fitness to drive assessments, as illustrated in the following exchange:

'Gry': *'When you've done liver function tests, can these be used as an indicator that he is drinking so much that it affects his health?'*

'Leif': *'You don't drive with your liver.'*

'Gry': *'No, you don't, but which parameters should you use then?'*

'Trond': *'It's much easier with older patients with obvious cognitive impairment. The signs are very apparent. And with other medications there are clear thresholds. But with alcohol it's like: what's the limit?'*

Several participants felt that assessments of medical fitness to drive were largely based on individual clinical judgement. Although clinical judgement is an integral part of general practice, use of discretion within a legal framework was considered alien and challenging. In a discussion on the interpretation of the regulatory framework governing the use of discretion, 'Nora' described it as follows:

'In the beginning, when the new regulation was introduced, we had the impression that there were more absolute requirements. But this was later corrected, allowing for greater use of discretion. However, that makes our work harder. It places even greater responsibility on GPs: you exercised judgement, yes, but it was poor judgement. Or if the patient realises that you are exercising judgement, and thinks that the doctor can choose whether to revoke the driving licence.'

Several participants expressed concern about personal consequences arising from incorrect interpretation of the driving licence regulation or failure to notify the County Governor. Some pointed out that risky or harmful levels of alcohol consumption trigger a mandatory fitness to drive assessment. 'Espen' said:

'I feel that if I've done a PEth test and it's high, and this is recorded in the patient's medical record, then I have to act. If the police arrive after a serious accident, you're expected to have documented this.'

Benefits of the legislation?

Despite the various challenging aspects of expert assessments related to alcohol use in general practice, several participants also identified benefits. One participant, 'Espen', highlighted the value of professional judgement and of knowing the patient's overall health situation when assessing medical fitness to drive:

'Who actually has insight into these matters? Should there be a doctor at Driver and Vehicle Licensing Offices taking mandatory blood samples, performing clinical examinations and assessments? That would remove the whole problem for us, but it's not easy to say who should do it other than us, because we do have a lot of insight.'

Several GPs saw potential for therapeutic benefit in the efforts to change patients' alcohol use. A temporary driving ban under the driving licence regulation may encourage compliance, both through the prospect of retaining or regaining fitness to drive status and through deterrence via mandatory reporting to the County Governor and follow-up monitoring. Espen described this as follows:

'During the first six months, you can issue a temporary driving ban and document it in the patient's medical record. This can be used as a form of gentle pressure to help people reduce their alcohol use. If their use changes, the ban can be lifted. (...) I think we need to use temporary driving bans effectively, and make all the consequences clear while motivating the patient.'

Discussion

Based on discussions and reflections among GPs attending a seminar on alcohol habits and health in general practice, this study found the role of expert assessor – and thus a mandatory reporting body – to be challenging. The following scenario will be familiar to many: a patient presents to their GP with health complaints; the doctor suspects that alcohol may be part of the problem, but the complex and uncertain implications of raising the issue makes the doctor hesitant to address alcohol use.

Although the harmful effects of alcohol are well documented, a discussion about alcohol also requires the doctor to consider legal aspects, including whether the patient is fit to drive.

The provisions of the driving licence regulation concerning alcohol are extensive, but rather vague in relation to assessing medical fitness to drive. Even the GPs who contributed to a study on alcohol-related health problems, and who might therefore be assumed to have a strong interest in quality development in general practice, found the regulation difficult to apply (27). According to the regulation, alcohol dependence, high consumption or harmful use do not in themselves automatically disqualify a person from driving; alcohol use must also be such that it may 'lead to behavioural disturbances and cause health impairment with an increased risk to road safety' (28). The recommendations from the Norwegian Directorate of Health therefore rely on

professional judgement. This may lead GPs, who often have to make such assessments in isolation rather than within a clinical community, to avoid discussing alcohol due to the complex and time-consuming nature of assessments.

The GPs' dual role as clinician and patient advocate on the one hand and expert assessor or reporting body on the other, can be challenging and lead to a breakdown of trust and complicate the patient-doctor cooperation (11). Other contexts in which the doctor's assessment can trigger intrusive measures in the patient's life include documentation for the Norwegian Labour and Welfare Administration (NAV) and notifications to child welfare services. It has been suggested that Driver and Vehicle Licensing Offices should have a doctor to perform medical fitness to drive assessments (29), allowing GPs to focus on maintaining the therapeutic alliance with the patient. However, GPs are probably in a better position to make a comprehensive assessment of a patient's health and whether they are medically fit to drive. It is therefore important to consider the extent to which GPs' dual role may discourage patients from seeking medical help or from discussing their alcohol use.

Our findings are consistent with previous studies showing that doctors sometimes choose not to request PEth testing even when the test is clinically indicated, for fear of having to assess medical fitness to drive (23, 30). PEth testing is a useful tool, however, both in clinical practice and in the follow-up *after* a patient has been deemed unfit to drive; however, the test does not provide a definitive answer to the question of fitness to drive (21, 31).

The findings also highlight how judicious use of the driving licence regulation may have therapeutic value. Where there is uncertainty about whether the legal requirements are met, the doctor can discuss this with the patient and facilitate constructive change processes. There is no duty to report cases where this is doubt, but the doctor should discuss openly with the patient how alcohol use may raise concerns about medical fitness to drive, and impose a temporary driving ban until this has been clarified. Furthermore, doubt indicates a level of alcohol use that may be harmful in the long term, and is a good starting point for further work on change, irrespective of whether the patient is ultimately deemed fit to drive. Our findings support the need for more standardised tools for assessing road safety risks associated with alcohol use.

Harmful use of alcohol and alcohol dependence are not uncommon (1), but few people seek help (32). A Swedish study found that treatment for mild to moderate alcohol dependence was equally effective when delivered by GPs as by specialists (33). We recently published an article on our seminar for GPs and how it helped normalise conversations about alcohol among participating doctors (34).

The data material in this study consisted of audio recordings of group discussions among GPs attending a seminar. The sample may therefore be biased, as participants may have had a particular interest in addiction medicine, been engaged in quality development in clinical practice, or found the topic especially challenging and wished to enhance their competence in this area (27). Moderated focus group interviews using an interview guide would

have been an alternative approach. However, the participants' familiarity with one another likely contributed to a safe discussion environment and to open and candid exchanges on the topic.

It remains unclear whether the current driving licence regulation and associated guide on medical fitness to drive improve health care and contribute to road safety, or whether they instead act as a barrier to seeking help and may therefore have the opposite effect.

The article has been peer-reviewed.

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