Can We Talk about Alcohol for a Minute? Thoughts and Opinions Expressed by Health Professionals and Patients at a Somatic Hospital

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Can we talk about alcohol for a minute? Thoughts and opinions expressed by health professionals and patients at a somatic hospital

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Abstract

This study aims to investigate the attitudes and opinions that are present among patients and health professionals towards addressing patients' alcohol use during a hospital stay. We conducted semi-structured interviews with nine health professionals and five patients to explore their opinions and attitudes towards *asking* and *being asked* about alcohol during a hospital stay. The data were analyzed using an ad hoc method consisting of primarily close reading and meaning condensing. The main barriers about alcohol as a topic in healthcare lie with health professionals. While patients have reservations and preferences regarding *when* and *how* they are asked about alcohol, they all consider knowledge about alcohol habits as important for the health professional to have. The study's results suggest that actions to better preventive efforts regarding inexpedient alcohol use should mainly focus on breaking barriers hindering the health professionals in asking their patients. This can be done by focusing on education for the health professionals on this topic and developing tangible guidelines for when and how to ask patients for the health professionals to depend on.

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Data availability statement

Data can be made available by writing to corresponding author, Anne-Marie Søndergaard Christensen, amsc@sdu.dk

1.0 Introduction

Alcohol use disorder (AUD) is responsible for considerable morbidity, mortality and accidents, and many patients with alcohol problems are admitted to general hospitals (Mdege et al., 2013). Among all patients hospitalized, the proportion of inpatients with AUD ranges between 16% and 26% (Roche et al., 2006), and excessive alcohol use, in particular, is considered to affect the prognosis of a series of illnesses (Andersen et al., 2012; Roerecke et al., 2017) and outcome of surgery (Eliasen et al., 2013; Rehm et al., 2009). It is estimated that each year the hospitals in Denmark have a total of 38,000 somatic and psychiatric inpatients and 89,000 outpatient visits that are alcohol-related (Eriksen et al., 2016), and patients who consume more than the recommended guidelines by the National Health Authorities have 110,000 extra contacts with their primary physician, compared to patients who drink less (Eriksen et al., 2016). Since many diseases and conditions are either caused by or affected by high use of alcohol (Rehm et al., 2009), hospital admissions have, thus, been considered to open a window for reviewing and affecting the patients' alcohol consumptions (Schwartz, et al., 2019).

Studies have shown that patients who, during hospitalization, have been approached concerning their drinking habits, reduce their alcohol consumption compared with control groups (Kaner et al., 2018). The barriers for systematic screening and swiftly interventions for excessive drinking and alcohol problems among hospitalized patients are, however, many. They comprise, in particular, barriers in relation to the healthcare provider, for instance high workload among staff, staff's fear of creating a conflict with patients, poor training, and staff's need to focus on medical issues (Hellum et al., 2016; Vendetti et al., 2017). Specifically, it has been found that although staff may find it relevant to talk about alcohol with patients who have an excessive use, they often find that they do not know enough about the signals of heavy alcohol use to be sure, and thus avoid bringing up the topic, in case they are wrong (Hellum et al., 2016). Studies have also shown that nurses are affected by how the doctors

prioritize addressing patients' use of alcohol. If the doctors do not pay attention to the patients' use of alcohol, the nurses are more reluctant to approach the patient about alcohol (Broyles et al., 2012; Hellum et al., 2016). It has also been found that knowledge about whether the patients' drinking is related to their illness seems to affect the nurses' attitude to approaching the patients. In a survey among nurses, inexpedient alcohol habits being related to the patients' illnesses has indicated to be facilitating raising the topic with the patients (Tsai et al., 2010).

One matter is the staff's view on whether or not to approach patients about their alcohol use, another matter is what the patients expect and how they receive being approached. Only a few studies have explored the patient perspective towards being approached concerning drinking habits. However, surveys in the general population indicate an overall acceptance of healthcare providers asking about patients' alcohol consumption on a routine basis (O'Donnell et al., 2018), and even that patients should expect to be asked. The acceptance of being approached by healthcare providers was also confirmed in a Danish alcohol screening and brief intervention study on parents to admitted children, in which only 1.4 % of the parents refused to participate due to the topic of alcohol (Bjerregaard et al., 2011). Not only did they not mind discussing their lifestyle habits; some even expected it (Bjerregaard et al., 2012). McCormick et al (2006) found that, when approached, the patients were likely to disclose information regarding their use of alcohol, and if the patients were satisfied with the healthcare provider in general, asking about alcohol does not seem to evoke resistance (Frankhaenel et al., 2018). The results indicate that patients may not be as opposed to talk about lifestyle issues as the staff's fear of patients' reactions indicate, but the field is still understudied.

As a preamble to the attempt to develop a helping tool for health professionals to help identify whether the patient in front of them at the hospital is likely to have an alcohol consumption that are risky, the

present study investigated the opinions and attitudes that are present among both staff and patients towards staff addressing patients' alcohol use. The investigation will unfold health professionals' and patients' attitudes, thoughts and opinions on addressing patients' alcohol use during the hospital stay.

2.0 Method and material

2.1 *Recruitment process/strategy*

The participants were primarily recruited at Odense University Hospital, Denmark, in The Department of Neurology, The Department of Orthopedics & Traumatology and The Department of Gastroenterology. Our overall goal was to interview two or three health professionals and two or three patients from each department. Due to short and varying number of admissions and an unpredictable work environment we were not able to ensure a specific number and variation of participants in advance.

Three patients were fit or willing to be interviewed on the days of the interviews. Since the interviewed patients expressed very similar thoughts and considerations, we decided to expand our study to include non-admitted, potential patients. We sought to ensure we had reached thematic saturation by means of a broader inclusion criterion. The rationale behind including non-admitted, potential patients was that everyone is a *potential* patient and has been to at least a/their doctor at some point in their life. Therefore, everybody can relate to, and have an opinion on, being asked about their alcohol use by a health professional. Furthermore, potential patients have more surplus of mental resources to consider the questions in the interview. Two additional participants in the patient group were, therefore, recruited through 'open call'.

2.2 *Ethics, consent and permissions*

Since the project was based solely on voluntary interviews and did not involve any biological material, The Regional Committees on Health Research Ethics for Southern Denmark deemed it unnecessary to apply to The Committees for permission to conduct the interviews.

The heads of each medical department were contacted beforehand via e-mail containing thorough information about the project. Together, we arranged a date with each of the medical department to come by and conduct the interviews.

To ensure that we did not interview patients who were either unfit for a full-length interview or unable to give their informed consent, we consulted the health professionals. Subsequently, they selected which patients would be physically and mentally capable of participating. This gave us an ethical assurance that the patients, who were interviewed, would not suffer in terms of wellbeing and could, in fact, give their informed consent. The patients were first approached by one of the health professionals, who gave them a basic outline of the project and asked them if they would like to learn more and maybe participate. This was to make sure that the patients did not feel uncomfortable by being approached by a stranger. Also, making the health professional establish first contact made our project more trustworthy and credible, as it assured the patients we did not just walk in off the street. Only if the patient were interested in hearing more about the project, the interviewer presented herself and the project in details.

Before starting the interviews, we obtained written consent from all the participants. The consent assured the participants confidentiality and anonymity. The participants were also informed that at any time in the process they would be able to withdraw their consent, if they wished to do so.

2.3 *Data collection*

A total of 14 participants were interviewed (nine health professionals and five patients). The health professionals were selected by the head of each department depending on availability on the day. The health professionals consisted of three medical doctors, four nurses and two social- and healthcare assistants. Eight of the health professionals were women and one was male.

Five patients were interviewed for this study, three of whom were patients admitted to Odense University Hospital. Not all of the approached patients wanted to participate. The remaining two patients were recruited through an 'open call'. The interviews with the admitted patients took place in their respective rooms in the hospital. The non-admitted patient interviews were held in a small office at the University of Southern Denmark. Three patients were women, two were male.

All interviews had a duration of maximum 30 minutes and were audio-recorded. All interviews were conducted by the same person (CO) using a semi-structured interview guide. Not having a health-related educational background meant, that CO was unfamiliar with the norms and rules in the health profession beforehand and thus had no conception whether asking about alcohol is considered good or bad practice in healthcare. This allowed CO to be open and perform the interviews without any prejudice.

2.4 *Data analysis*

The audio files were transcribed in Word and analyzed ad hoc. This ad hoc analysis consisted primarily of close reading the printed transcriptions and a process of meaning condensing and color coding by hand. The analysis was primarily carried out by CO and sent back and forth to AMC, RC and AN who then evaluated and gave feedback on the analysis independent of each other. AMC, RC

and AN also had the full transcriptions and could, therefore, make qualified comments and make sure that nothing had been missed or needed further exploration.

3.0 Results

3.1 *Health professionals*

A total of nine health professionals took part in the interviews investigating their attitudes and opinions on asking patients about their alcohol habits during a hospital stay. To achieve a meaningful and in-depth answer to this question, the respondents were asked about their opinion on several closely related questions, including their general opinion on systematic questioning about alcohol- and lifestyle habits and their personal experience regarding asking patients about alcohol habits. This way we were able to detect any inconsistencies and get a more nuanced impression about their attitudes on the matter.

When asked about their opinions on systematic questioning about alcohol consumption - even when not directly related to a patient's admission - seven out of the nine health professionals were positive. The reasons behind this varied, but most argued that alcohol *could* be of relevance to the patient's disease or treatment and was, therefore, important to have knowledge about. The remaining respondents were somewhat ambivalent about the systematic questioning of patients or did not care much about the patient's alcohol habits.

The question about how they *experienced* asking patients about alcohol revealed that although most of the respondents were positive about systematic questioning of patient's alcohol habits, they also considered the conversation about alcohol can be a difficult one to have. It was, however, a subtle finding. While the respondents directly expressed that systematic questioning the patients about their

alcohol habits was not difficult, almost all also gave examples that indicated that questioning about alcohol was not always straightforward. The examples thus contrasted how the respondents directly stated that they did *not* find the conversation difficult at all, for instance when the respondents - unsolicited - mentioned circumstances that made it *easier* for them to ask patients about alcohol habits. If someone unsolicited mentions circumstances that make an action *easier*, this must necessarily mean that this action is not as easy to begin with, as first expressed.

Overall, the respondents who were positive about systematic questioning about alcohol habits also at the same time expressed difficulty with the conversation. A general positive attitude towards systematic questioning does thus not necessarily mean that the conversation is *experienced* as an easy one to have.

The respondents highlighted three categories of circumstances that made questioning about alcohol easier i) systematic questioning, ii) having specific reasons, and iii) work experience. However, in the interviews, the health professionals did not just mention circumstances that make asking *easier*, they also highlighted circumstances that make asking *more difficult*, namely multi-bed wards. We will return to the challenges connected to multi-bed wards after reviewing the circumstances that make it easier to ask.

Two of the respondents mentioned *systematic questioning* as a circumstance that made it easier to ask and talk about alcohol with the patients. The effect of implementing a procedure of systematic questioning was found to remove potential stigma and the possibility that a particular patient feels deviant. As HP-2 puts it: "(...) when it becomes systematic (…) you ask about a lot of things (…) it becomes systematic and you are not thinking, that, that it is like person-directed (...) then it's easier

(…)". Systematic questioning becomes a sort of tool to dissolve the possible judgemental character of the question about alcohol. The same effect of systematic questioning as an impersonal way to ask was expressed by HP-7: "(...) the more systematic it becomes, the easier it should also be (to ask, red.), because then it is not person-directed anymore (…) the more part of standard procedure it becomes, the easier it should be for everybody to dare ask (...)". Although they both talk about systematic questioning as something that creates this impersonalization, they addressed it in two different ways. For HP-2 systematic questioning is a means for the *patients* to not feel personally attacked or accused by the question which, thereby, makes it easier for the health professional to ask. The reasoning behind this must be, that if the health professional can avoid making the patient feel personally attacked, thereby hindering any negative response, this makes the asking less difficult. For HP-7, on the other hand, the systematic questioning is regarded as a means of shielding the *health professional* in such a way that the patient does not think that it is the individual health professional who suspects and accuses the patient of drinking too much, thereby making it easier to ask. This, however, does not change the fact that both HP-2 and HP-7 consider systematic questioning as something that makes it easier for them to ask patients about alcohol.

The second circumstance the respondents mentioned made asking easier was *having reasons*. The specific reasons varied, e.g. a professionally founded judgement or a non-professional (or personal) hunch or suspicion. But they all shared a common feature: they give the health professionals a feeling of being validated or authorized in asking the patient about alcohol habits. As HP-3 puts it: "(…) if you suspect something, then you kind of feel like you have a valid reason for asking (...) when you like do not have that suspicion and walk in and ask, then I actually think it can be a little hard (...)". Having the circumstance such as a reason – whatever kind of reason – makes it easier for some health professionals to ask patients about alcohol because it makes them feel justified in doing so. *Having*

reasons so to speak removed the fear of offending a patient since the reasons justified the questioning, just like procedures about *systematic questioning* also justified it.

The third circumstance - work experience - was mentioned by some of the health professionals. Asking about alcohol was referred to as something you get used to as you gain more work experience in the field. HP-5, who works in a department where a lot of the patients come in with alcohol related diseases, puts it like this: "(...) also because of the patients we have – we are used to talking about it, so it not, like, hard (...)". So, when you are used to asking and talking about alcohol with patients it makes it easier to do. HP-6 talked about it as something you *learn*: "(...) well, I have been in the profession for many years, so, I think it is something I have learned (...)". Asking about alcohol is something that you *learn* by experience – something you get used to, thereby learning to do it in a good way.

As mentioned earlier, the interviews did not only reveal circumstances that made asking about alcohol easier but also a circumstance that made asking more difficult. Two of the respondents mentioned multi-bed wards as something that caused the conversation about alcohol to be harder to handle. As HP-7 puts it: "(...) what I almost find to be the hardest is that we have (…) a lot of the patients in big wards (…) then you have to have it (the conversation, red.) in a 4-bed ward (...)". The respondents stated that the 'consequences' of having to ask a patient in a multi-bed ward are, on the one hand, that the patient might be embarrassed by being asked in front of other patients, and on the other hand, that it makes it harder to get an honest answer out of them.

During the interviews, the respondents shared their reflections and perspectives on what it is about alcohol that makes it a difficult subject. These reflections can be condensed into 3 characteristics of

alcohol that they found might be the cause for it being difficult subject to talk about. The first characteristic about alcohol was that it is a form of social taboo and something that both health professionals and patients can be prejudiced about. This was expressed by HP-1 from a health professional perspective: "(…) it is something that people can experience as a taboo subject… if you don't have that much experience in talking with people (...)". Having this feeling of alcohol being a taboo subject makes it hard for the health professional to ask about it. Taking the patient perspective, HP-3 says that: "(...) a lot of people get defensive (when asked, red.) because it still is a taboo (...)". So, even if the health professional does not consider it a taboo subject themselves, the health professionals consider that it might be taboo for some of the patients.

The second characteristic of alcohol mentioned by the health professionals was that they considered it is embarrassing for the patient to talk about. HP-8 – who said that patient's alcohol habits do not have any relevance – even said that some patients find talking about their use of alcohol embarrassing: "(…) some are embarrassed about eating too much, some are embarrassed about drinking too much (...)". But it is not only the patients who can find alcohol embarrassing. As with the first characteristic it applies to both perspectives. The health professional perspective was mentioned by HP-1, who stated that for those without much experience in the field, alcohol: "(...) is a bit embarrassing to talk about (...)".

The third and last characteristic about alcohol mentioned by the respondents was that alcohol is a private and personal issue. HP-8 stated, as follows, about the patients who drink more than recommended: "(…) as far as I am concerned, they can do it, that's a private matter (…)". The same point about alcohol being a private matter was expressed by HP-1, although in a quite different way. She mentioned this in connection with the health professionals who are new to the field and who

might think: "(...) can I really take the liberty to do that – to talk to people about that, that's their problem (…)". To doubt whether one can take the liberty to talk to patients about alcohol because it is regarded as *their* problem indicates that some, indeed, perceives of alcohol as a private matter.

3.2 *Patients*

A total of 5 patients took part in the interviews investigating patients' attitudes and opinions on being asked about their alcohol habits during a hospital stay. As with the interviews with the health professionals, these interviews also consisted of a number of closely related questions regarding their attitudes and opinions on the matter. Besides the main question, it included questions about their opinion on whether health professionals should ask about alcohol- and lifestyle habits, and whether or not the respondents find knowledge about this to be important for the health professional in order to assess a patient's general health status. This was done to generate a base for a nuanced and in-depth answer to the main question, and it also made it possible to detect any inconsistencies in their answer.

The patient interview started with an open question about whether the respondents had ever experienced a health professional asking them about something that they did not find relevant in the situation. Asking this initial open question enabled them to think back on any such experience they might have had without being primed to think specifically about alcohol. Not one of the patients could recall ever having experienced such a situation.

Some patients answered, without any hesitation, that they were OK with being asked about their alcohol- and lifestyle habits. One of them (P-1) pointed out that alcohol dependency, in her opinion, is a disease that requires professional help and should therefore be something that the health

professionals asks patients about. Others (P-4 and P-5) had some reservations about being asked. When asked how she would feel about a health professional questioning her on her alcohol- and lifestyle habits, P-4 answered: "(...) I think it is okay to be asked about, but it really depends on how much weight they put on it in the conversation" (...)". The weight she finds appropriate depends on how *relevant* she thinks alcohol is to the current health issue she is being treated for. She also pointed out the importance of being heard and being taken seriously by the health professional regarding the current health issue. P-4's reservations about being asked can be condensed to the following three criteria rendering it okay for the health professional to ask: i) that the patient understands why alcohol- and lifestyle habits are relevant in the situation, ii) that she has a feeling of heard and that her 'original' health-related issue is being taken seriously and, iii) that there is a balanced focus on the current health-related issue and questions about alcohol- and lifestyle habits – the latter must not overshadow the former. If these three criteria are met, P-4 does not have any issue being asked about her alcohol- and lifestyle habits.

P-5's reservations about being asked were somewhat similar to P-4's. Relevance was also an issue for P-5. She said that if she could not understand the relevance of alcohol- and lifestyle habits to her specific health related issue, then asking about alcohol would make her annoyed. Another thing that was essential for her to be okay with being asked was that it would have to be done in a non-judgemental way. As she put it: "(...) the trick is to meet the patients where they are at (...) which requires the ability to read the patient and also take the time to get to know the person in front of you (...)" (P-5). If she understood the relevance and felt that she was being asked in a non-judgemental way, then she was OK with being asked. To summarize, it was not *being asked* that in itself posed a problem for P-4 and P-5, but *how* they were to be asked. This sets some requirements to the health

professionals regarding: 1) how they should ask, 2) that they make sure that the patients do not feel judged and, 3) that they convey the importance and relevance of them asking in the first place.

When asked whether they think alcohol- and lifestyle habits are something that health professionals ought to ask about, all the patients believed they should do so. Some of the patients answered 'yes' in a very categorical way, while others – even though they thought it should be done – had some reservations about it. Patients P-2 and P-4 answered that the health professionals should only ask about alcohol- and lifestyle habits when it was *relevant* to the cause of the individual patients being admitted or visiting their doctor. In other words, in their opinion, the health professionals should only ask patients about alcohol- and lifestyle if this was relevant to the treatment of the patient. Later in the interview P-2 pointed out, that this was almost always the case.

Although she was interviewed as a patient, P-5 pointed out, quite early in the interview, that she had difficulty putting her profession aside, and that this could result in some contradicting answers. As a result, she every now and then shifted back and forth from a patient- to a health professional perspective. This was also the case during this question about whether health professionals ought to ask patients about alcohol. From a professional perspective she did not hesitate to answer that health professionals should always ask about patient's alcohol- and lifestyle habits, because it is important knowledge for the health professional in relation to treatment and preventive care. However, from a patient perspective, she was more reluctant to give the same straight-forward answer. From this perspective, she emphasized the importance of the health professional being able to assess the individual patient's case, so that addressing this issue would not come across as judgmental. This means that P-5 was of the opinion that health professionals *should*, indeed, ask patients about their alcohol- and lifestyle habits but that when they do, they need to make sure they do so in a non-

judgmental way. P-5's shift in perspective does not necessarily mean that her opinion on this matter is conflicting. One can be of the opinion, that health professionals *should* ask about alcohol- and lifestyle habits and at the same time have an opinion about *the way* the asking should be done. To sum up, none of the patients thought that the health professionals should *not* ask, but three of them had some reservations about/criteria for *how* and *when* the asking should be done.

To the question whether knowledge about alcohol- and lifestyle habits are important for the health professionals to assess a patient's health status, four out of the five patients answered that it *is* important knowledge. P-2 did not think that knowledge about alcohol- and lifestyle habits was always important. In his opinion there are some cases where this knowledge is not relevant to this assessment of health, but, at the same time, he also stated that, in most cases, it would be. Therefore, he is categorized as someone who thinks it *is* important knowledge.

4.0 Discussion

This qualitative study has explored the attitudes and opinions of both health professionals and patients in relation to asking patients and being asked as a patient about alcohol- and lifestyle habits during a hospital stay. It provides relevant insight, from a professional and patient perspective, on how to go about the topic of alcohol in healthcare settings.

4.1 *Patients*

Overall, the patients we interviewed were very positive about being asked about alcohol- and lifestyle habits. Two of them conditioned their positive attitude towards being asked with reservations, which can be summed up in the following two criteria: 1) that alcohol should in some way be relevant to their condition and, 2) that the asking should be done in non-judgmental and professional way. These

criteria about being asked were consistent with the reservations voiced in relation to the general question about whether health professionals *ought to* ask about alcohol. In the answer to this question, both of them repeated their reservations about relevance and how the asking should be done. None of the patients we interviewed were of the opinion that health professionals should *never* ask about alcohol- and lifestyle habits, which is consistent with all of the patients regarding knowledge about alcohol- and lifestyle habits as important knowledge for health professionals.

These findings reflect previous findings, that patients are not reluctant or hostile towards talking and being asked about their alcohol habits in a healthcare setting (O'Donnell et al., 2018; Bjerregaard et al., 2011; Bjerregaard et al., 2012; Frankhaenel et al., 2018). Although some of the patients had reservations about how and when to be asked, none of them thought of alcohol- and lifestyle habits as something that patients should *not* be asked about. This willingness from the patients to be asked and talk about their alcohol- and lifestyle habits is important knowledge for the health professionals in order to reduce barriers for them asking. If you do not expect a bad reaction from a patient, when asking about alcohol, it becomes an easier task to ask questions about this issue. Also, knowledge about the reservations, expressed by some of the patients, can be put to use in the education and training of health professionals, helping them to be better equipped to handle conversations about alcohol. Having knowledge about *when* it is the right time to ask and *how* to go about the asking in a way that does not come off as judgmental, are important tools in bringing down the barriers for health professionals and, thus, improving the preventive effort regarding alcohol related health issues.

4.2 *Health professionals*

Our findings regarding health professionals' attitudes and opinions on asking patients about their alcohol- and lifestyle habits are also in accordance with previous findings in this field (Vendetti et

al., 2017; Hellum et al., 2016). While most of the health professionals, we interviewed, were overall positive about systematic questioning about alcohol habits, most of them also stated, indirectly, that the conversation about alcohol *can* be a tough one. This was confirmed by our respondents' spontaneous mentioning of circumstances that either makes asking easier or harder which is, indeed, an indication that this topic is a difficult one.

In order to improve the preventive efforts, we need to make sure that health professionals feel confident and comfortable enough to ask patients about their alcohol habits. In this perspective, knowledge about the circumstances that makes it easier and harder for them to ask is important and helpful and can help to better this effort. We found that systematic questioning was making it easier to ask patients about topics like alcohol, because it makes the asking less person-directed. When asking about alcohol becomes part of a standardized routine, it might remove the fear of signaling that the question is asked because the patient *comes across as* or *looks like* a person who might drink excessively. This finding indicates that there may be a need for the development and implementation of tangible guidelines and routines about how to ask about lifestyle issues, which would help make health professionals feel comfortable asking and, thereby, actually doing it.

In our study we also found that *having reasons* facilitates the health professionals asking about alcohol. This seems to indicate that the relevant education and knowledge about alcohol use, alcohol dependence, and how both relate to illnesses and health, can be a fruitful way of making sure that the health professionals feel confident and justified in asking patients about alcohol because they know they have solid clinical reasons for doing so. Finally, we found that work experience was a factor when asking about alcohol. This factor points to the importance of training and supporting

unexperienced health professionals about how to handle the situation when asking patients about their alcohol habits.

To ensure that more health professionals ask about alcohol, it is essential to know exactly *what* prevents them from asking. The present and prior studies provide a qualified answer to this question, thereby pointing to a meaningful way of bettering the preventive effort regarding the health challenges, posed by alcohol, for the individual patient and for the healthcare system as a whole. Knowledge about *what* it is about alcohol that makes it a difficult subject is, however, also an important aspect when it comes to breaking down barriers and making it an easier subject for health professionals to ask and talk to patients about. The health professionals we interviewed pointed to some of these barriers being related to alcohol being considered: 1) a social taboo, 2) embarrassing to talk about and, 3) a private and personal issue. This knowledge is important in the process of counteracting these barriers and concerns that are at stake when health professionals must bring up alcohol in a patient conversation.

4.3 *Limitations*

Even though this study reached the same results as previous studies (Vendetti et al., 2017; Hellum et al., 2016; O'Donnell et al., 2018; Bjerregaard et al., 2011; Bjerregaard et al., 2012; Frankhaenel et al., 2018) there are a number of limitations to the study. First, the number participants interviewed for this study was limited. Despite a good correlation between the respondents' answers, a recommendation for further study would be a quantitative study with the same research question. This would strengthen the study by ensuring a broader population and confirm or dismiss the correlations of opinions found in this study. Another obvious way to further this research would be to investigate a correlation between patient's alcohol consumption and their opinions on being asked. The second

limitation is that the patients we sought out were admitted and did not necessarily have the strength to participate in an in-depth interview regarding this topic. Although health professionals evaluated which patients, they considered to be able to participate, this does not guarantee that they actually had the surplus of mental resources necessary to consider and contemplate their opinions on the matter. Also, because some of the admitted patients were admitted in multi-bed wards, they were interviewed during the presence of other patients in the room. This may have made them feel uncomfortable and, thereby, negatively affected the fullness of answers and their level of honesty. Third, the health professionals were interviewed while they were at work and therefore had a limited amount of time available. This could have had an impact on their concentration and mental presence and therefore could be a potential limitation to this study.

5.0 Conclusion

Our main findings in this study support previous findings that health professionals, more than patients, have issues and barriers regarding the subject of alcohol. While some of our patients had reservations about *how* and *when* they found it acceptable to be asked about alcohol, they all agreed that alcohol habits are important knowledge for a health professional and that they, therefore, ought to ask about this. Timing seems to be of huge importance. This suggests that the main efforts to better the preventive work should be focused on the health professionals by equipping them with relevant education and knowledge on the matter and implementing tangible guidelines and routines for asking patients about alcohol habits.

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