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Repérage des conduites addictives en soins primaires : regards croisés entre médecins de soins premiers et patients

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Serment d'Hippocrate

Au moment d'être admis à exercer la médecine, je promets et je jure d'être fidèle aux lois de l'honneur et de la probité.

Mon premier souci sera de rétablir, de préserver ou de promouvoir la santé dans tous ses éléments, physiques et mentaux, individuels et sociaux.

Je respecterai toutes les personnes, leur autonomie et leur volonté, sans aucune discrimination selon leur état ou leurs convictions. J'interviendrai pour les protéger si elles sont affaiblies, vulnérables ou menacées dans leur intégrité ou leur dignité. Même sous la contrainte, je ne ferai pas usage de mes connaissances contre les lois de l'humanité.

J'informerai les patients des décisions envisagées, de leurs raisons et de leurs conséquences.

Je ne tromperai jamais leur confiance et n'exploiterai pas le pouvoir hérité des circonstances pour forcer les consciences.

Je donnerai mes soins à l'indigent et à quiconque me les demandera. Je ne me laisserai pas influencer par la soif du gain ou la recherche de la gloire.

Admis dans l'intimité des personnes, je tairai les secrets qui me seront confiés. Reçu à l'intérieur des maisons, je respecterai les secrets des foyers et ma conduite ne servira pas à corrompre les mœurs.

Je ferai tout pour soulager les souffrances. Je ne prolongerai pas abusivement les agonies. Je ne provoquerai jamais la mort délibérément.

Je préserverai l'indépendance nécessaire à l'accomplissement de ma mission. Je n'entreprendrai rien qui dépasse mes compétences. Je les entretiendrai et les perfectionnerai pour assurer au mieux les services qui me seront demandés.

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Repérage des conduites addictives en soins primaires : regards croisés entre médecins de soins premiers et patients

RESUME

Introduction : Les conduites addictives entrainent une morbi-mortalité importante, et un coût social majeur. Un repérage précoce de ces comportements en soins primaires est nécessaire, mais insuffisamment réalisé malgré les recommandations internationales. L'objectif de cette étude était de croiser les points de vue de médecins de soins premiers et de patients sur leurs expériences vécues et leurs attentes vis-à-vis du repérage afin d'en comprendre les difficultés.

Matériel et Méthode : Deux études qualitatives, multicentriques ont été menées aux cours d'entretiens individuels semi-dirigés, auprès d'un échantillon raisonné de médecins de soins primaires et de patients consultants des professionnels de santé. Les entretiens ont été enregistrés, anonymisés, retranscris, et analysés selon la méthode de théorisation ancrée.

Résultats : Quatorze médecins et quinze patients ont été interrogés. Médecins et patients décrivaient une première étape de pré-repérage, dans laquelle le médecin dépistait un patient avec un usage problématique, avec, en parallèle un patient qui se reconnaissait avoir un trouble et identifiait un professionnel potentiellement source d'aide dans sa prise en charge. Parler d'addiction nécessitait de s'affranchir de ses représentations et de ses craintes, avec d'un côté pour les médecins la peur de perturber la relation et de ne pas être compétent, et d'un autre côté la peur du jugement ressentie par les patients. Le dévoilement des patients, comme levée de ces obstacles, était conditionné par un ensemble de facteurs favorisants. Enfin, le repérage était décrit comme une rencontre entre les attentes de chacun permettant d'initier le changement.

Discussion : La conceptualisation obtenue par l'analyse croisée des discours de médecins et de patients a permis de souligner les convergences et divergences des points de vue de chacun, et d'apporter des éléments de réponses en ce qui concerne les conditions amenant au dévoilement et au repérage des troubles addictifs des patients. Elle vient compléter des études antérieures et enrichir un panorama de points de vue des différents acteurs sur le sujet. L'aboutissement à une théorisation ancrée complète permet une prise de conscience des réalités du terrain, d'apprendre à partir des points de blocage, avec la perspective de construire des outils d'aide à la pratique quotidienne, dans le but d'améliorer le repérage précoce.

Mots clés : *addiction, repérage, soins primaires, étude qualitative.*

Screening of substance-related and addictive disorders in primary care: crossed looks between primary care providers and patients

ABSTRACT

Introduction: Addictive behaviours lead to high morbidity and mortality, and represent a major social cost. Early identifying these behaviours in primary care is necessary, but insufficiently carried out despite international recommendations. The objective of this study was to compare the views of primary care physicians and patients on their experiences and expectations regarding screening in order to understand the difficulties involved.

Method: Two qualitative, multi-center studies were carried out during semi-structured individual interviews with a purposive sample of primary care physicians and patients consulting healthcare professionals. Interviews were recorded, anonymized, transcribed, and analyzed according to the grounded theory method.

Results: Fourteen doctors and fifteen patients were interviewed. Doctors and patients described an initial pre-screening stage, in which the doctor detected a patient with a substance use disorder, and in which patient recognized himself as having a disorder and identified a professional who could help in his care. Talking about addiction means freeing oneself from one's own representations and fears, with, on the one hand, the doctors' fear of disturbing the relationship and not being competent, and on the other hand, the fear of judgment felt by patients. The disclosure from patients, as a way of removing these obstacles, was conditioned by a set of enabling factors. Finally, screening was described as a meeting of individual expectations to initiate change.

Discussion: The conceptualization obtained through the cross-analysis of doctors' and patients' discourses has highlighted the convergences and divergences of each one's points of view. This study provided elements of answers regarding to conditions leading to the screening of patients' addictive disorders. It complements previous studies and enriches a panorama of points of view of different actors on the subject. The outcome to a complete well-grounded theorization, allows an awareness of the realities in the field, to learn from the blocking points, with the perspective to reach the construction of tools to help daily practice in order to improve early screening.

Key words: *addictive behaviour, screening, primary care, qualitative research*

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BACKGROUND

Despite a great variability in epidemiological burden, all addictions, with or without substance, have in common a high morbidity and mortality, and a social cost, that can both be reduced by appropriate interventions[1-3]. Screening patients suffering from addictive disorders is relevant as it decreases mortality and improves quality of life[4-7].

In response to these epidemiological challenges, successive World Health Organization (WHO) reports have prompted health authorities to launch new policies to prevent and control addictive substances[1]. Among others, France, the UK, and the USA have published dedicated guidelines[9-11]. The screening methods advocated relied mainly on a protocol of "screening and brief intervention" (SBI). The US research literature often refers to SBIRT (Screening, Brief Intervention and Referral Treatment) based on a global approach, combining identification, brief interventions and therapeutic recommendations.

Although the use of SBI or SBIRT in primary care settings has been validated, it is under-used, and the screening part is poorly described[12-13]. Various barriers to screening have been mentioned and assessed in quantitative studies, including lack of time, feeling of ineffectiveness and patient's reluctance[14-16].

Primary care providers have a specific setting that enables them to promote screening and prevention of addictive disorders, because they are easy to access due to their wide implantation on territory. They have a global approach to the patient, between health, social and environmental issues[17]. Today's modern general medicine encourages the use of specific skills such as patient-centred approach, which facilitates the use of SBIRT[18]. Lastly, a small investment in primary care can greatly reduce health costs in hospitals[19]. Views of people who are not currently affected by an addiction problem allow us to get to know their representations, reluctance, and expectations about this screening. Specific mechanisms and issues combining practitioners and patient's impediments could be involved and should be sought.

The objective of this study was to cross-reference the view of primary care physicians and patients' representations in the early identification of addictive disorders and to highlight barriers to screening related to their interaction.

METHOD

Two multicentric qualitative studies involving primary care physicians and patients were conducted between June 2018 and June 2020, in Centre-Val de Loire, Nouvelle-Aquitaine, Ile-de-France, Pays de la Loire and Bretagne regions.

DESIGN

A first research involved general practitioners, doctors of occupational health, doctors working in university prevention center *"Service Interuniversitaire de Médecine Preventive et Promotion de la Santé (SIMPPS)"*, free testing center for sexually transmitted diseases *"Centres Gratuits d'Information, de Dépistage et de Diagnostic (CeGIDD)"* and planned parenthood center. The first contact was made by e-mail, by telephone or on the spot.

A second research involved patients. Recruitment was done in the waiting rooms of general practitioner, midwife, school nurse, physical therapist and pharmacist.

The research was reported in accordance with the COREQ and SRQR guidelines for reporting qualitative research[20-21].

POPULATION

For practitioners, the only one criterion inclusion was to work in primary care settings. For patients, the criteria were to be of legal age, and not having a caring relationship with investigator.

The reasoned samples were based on predefined criteria to obtain the global variety of activities and characteristics. Subsequent sampling followed the needs depending on the findings of the ongoing analysis and the constant comparison process.

DATA COLLECTION

In both studies, semi-structured face-to-face interviews were conducted with patients or professionals. Interview guides were specific to each population. On one side, it was designed to explore the screening experiences of the practitioners: to discuss of successful and unsuccessful early identifications, to talk about working with specialists, and what could be improved in screening in primary care. It has been adapted to the structure and the audience received. On the other side, interview guides included an "ice-breaker" question about a situation perceived as embarrassing by the patient during a consultation, and then addressed real-life situations of addictive disorders screening, and what is expected from professionals. Guides were modified through the whole data collection process to include new concepts that emerged during the simultaneous analysis *(Appendix 1 & 2).*

All the interviews were recorded and fully transcribed for analysis. They were carefully anonymized during the transcription.

ANALYSIS

The doctors' and patients' viewpoints were collected and analyzed by a conceptual approach according to the model of grounded theory[22]. The verbatim of each interview was coded using the principle of data triangulation. Initial coding was done independently by two analysts, and discrepancies were resolved by discussion, with the arbitration of a third analyst if needed. Categories were built from the initial coding using the same triangulation procedure. This inductive analysis allowed to describe some concepts. These concepts were compared, convergences and divergences were identified and analyzed to build an explanatory model[23].

All the analyses were conducted using QSR NVivo1.3.2®.

ETHICAL ASPECTS

All participants signed an informed consent form *(Appendix 3).*

The *Espace de réflexion éthique région Centre* board gave a favourable opinion on the conduct of this study (N°2017-059, le 09/01/18) *(Appendix 4).* This study is registered with the *commission nationale de l'informatique et des libertés* (CNIL) under N°2017-093 *(Appendix 5).*

RESULTS

14 practitioners in primary care and 15 patients were interviewed. Theirs characteristics were summarised in Table 1 and 2.

GET TO KNOW …

Patients don't really see the prevention role of doctor's: *"I came to see him more for little everyday sores, and he didn't ask me these questions. Perhaps also in relation to my age, he didn't think I smoked"*$_{P15}$ *;*

They think that, because they seem to be in good health, the doctor don't ask them if they have addictions: *"I think he sees someone who drinks, smokes or something like that, you know…"*$_{P6}$ *; "he knows that I do a lot of sport"*$_{P12}$*.*

If doctor ask them if they have an addiction, the answer is simple, because they don't feel concerned: *"I don't smoke so I don't feel concerned"*$_{P2}$ *; "these are things we talked about, but I don't smoke, I drink very very little, so I don't feel concerned"*$_{P4}$*.*

Doctors seem to understand that patients have specific expectations depending on their position like in planned parenthood center *"they don't come for that (…) Here we are going to talk about gyneco (...) I think they really come for that, they aren't necessarily here to talk about other things or they don't necessarily want to..."*$_{D10}$ or in occupational health where they come for a validation "*it's me at the end who signs the notice of aptitude or not"*$_{D8}$. Moreover, depending on the specialty, doctors do not consider the subject to be part of their role "*at planned parenthood center, we're not the center where we're necessarily going to take care of addiction and here I, I don't want to detect addiction at all costs (...) What I want at all costs is to have offered them contraception or the subject for which she came*"$_{D10}$.

… AND IDENTIFY EACH OTHER

Patients become aware of the role of the professional, they understand that doctors can ask intimate questions : *"I think it's important for a professional, if he has the slightest suspicion, to try, by asking a question a little off the mark, try to get to the field of addiction"*$_{P5}$ *; "Sometimes if the person is depressed, the doctor may be looking for the reason, so he may sometimes ask much more intimate or personal questions"*$_{P10}$ *.*

People think that professionals are competent to diagnose addictions: *"he has scientific knowledge, which can help us, prove to us, that if we take this decision it can be better for our health"*$_{P8}$*.*

Doctors are aware that some patients do not identify themselves as having a problematic use, by lack of knowledge "*I don't think he was aware that it was overconsuming*"$_{D8}$, by lack of awareness "*I remember how a patient... who wasn't really aware at all of the risks he was taking*"$_{D7}$, by minimizing their consumption "*So often... people tend to downplay, so... It's not easy to get the real objective answer*"$_{D4}$, and because of denial "*excessive drinkers and who... were in complete denial, it happens too, and for which the conversation can't go any further in this case*"$_{D11}$.

Among the interviews we realized, we have identified environments that favour disclosure like at the SIMPPS "*here it's also a preventive medicine service, (...) there's maybe a side where we feel more legitimate… to ask the question, because even if they come for something somatic… we're labelled as a preventive service, so at the end if we ask that kind of question, it's accepted*"$_{D6}$, and at the CeGIDD "*the speech is supposed to be quite free, there is a guarantee of anonymity at the CeGIDD and so ... the patient will be able to speak freely … Then, we talk about sex from the very first seconds in fact. So, after that the question of addiction isn't that much taboo anymore*"$_{D7}$. In opposition, in occupational medicine's structure, patients seem to be distrustful "*they don't necessarily have an interest in telling us sometimes, forklift operators for example, you see, so they don't necessarily have an interest in telling us that they smoke... that they smoke cannabis or things like that*"$_{D8}$ and seem to be suspicious "*for the occupational physicians they think we're going to go and tell the employer*"$_{D12}$.

SIMPLE QUESTION, BUT BIG TROUBLE

For people, it is no easy to talk about addiction, due to the feelings of shame, guilt and the fear of judgement: *"I think it's, already the word addiction, it's negative, we are afraid of being judged"*$_{P5}$ *; "the word addiction it's immediately frightening it might stigmatize a little bit"*$_{P13}$*.*

But patients are ready to share their intimacy with the professional that they choose: *"for questions related to women, I would rather go to a gynaecologist, even a man; as he was a gynaecologist I found it quite normal to tell him"*$_{P11}$ *; "It depends on what we call intimacy, after which it's up to each of us to find our own level of intimacy, and with whom we are willing to share it, for our own good"*$_{P6}$*.*

Professionals described the fear of disturbing doctor-patient's relationship by talking about addiction, like the risk of losing the follow-up "*I'm not the only one, that we see it has a problem and that we discuss the subject and that in if any case we insist too much we won't see them anymore*"$_{D3}$, the fear that patients feel stigmatized or doing wrong "*my aim is to make them not feeling judged*"$_{D10}$; "*No, I never told her about it. I say to myself she'll tell me about it... then I didn't want to hurt her, I told myself if I tell her, she's certainly going to brace against (...) She's having her own difficulties so I didn't want to give her any more reason to show her, her difficulties*"$_{D9}$.

Addiction approach may depend on its own experience *"inevitably everything that concerns us personally or those around us has repercussions on our professional life"*$_{D11}$ and representations *"in my representation of this person it was someone who could have a depression but whom for me wasn't supposed to be an alcoholic at 25 or 26 years old, (…) I hadn't discussed this problem with her at all"*$_{D11}$.

Doctors revealed the fear of not being competent to take care of them *"So, identifying is okay. But it's for the "after" or where I'm less sure of being really … in addition, here, we quickly address to... the psychiatric cell..."*$_{D6}$ with an insufficient training on the subject *"this is something that we are missing in our studies, unfortunately"*$_{D1}$.

They express the feeling of discouragement *"I have the impression that I am... a bit helpless. It's not... I don't have my role... I'm not sure I can do miracles"*$_{D3}$ and frustration "*He completely denies the problem. There's no question of making him change his habits... I tried several times to come back to the subject but I think it's all over*"$_{D4}$, with an impression of being alone faced to these situations *"It's difficult, this kind of patients... we don't know how to help anymore. And then you feel that medical structures, they are no longer interested to them"*$_{D14}$.

Asking the question is not simple as that, several doctors told that they use strategies to talk about addiction *"for me if they don't want to talk about it or if they not reply to a question that was really precise while I really feel it's a yes (…) I'm not going to insist. Because I think it will be badly perceived and on the contrary, I think they maybe will talk to me later on because I didn't insist"*$_{D10}$ or *"It's part of several questions so they don't necessarily feel that I suspect"*$_{D6}$.

Furthermore, patients are aware of how difficult it is for the doctor: *"If the person feels that the doctor is embarrassed, it can be annoying for the person who has to talk about it"*$_{P7}$*; "there are certainly situations that refer to the doctor's own experience, so it can indeed be a kind of projection in relation to the person who testifies before him"*$_{P6}$.

WHO SHOULD SPEAK FIRST?

People are waiting for a move from the professional: *"there is a certain reserve that I would keep personally about things, and then I think the person I came to see must ask me questions to get me to tell me how I feel"*$_{P5}$*; "Because we're not going to tell the doctor on our own, we're not going to tell him, he has to ask us questions, we'll answer what we want, but it's working on us afterwards"*$_{P6}$.

For some doctors, the patient is the actor in their care process *"from the moment he gets involved in his care I think he will tell us about it. But if he doesn't get involved in his care he won't talk about it"*$_{D9}$, and

they will talk about it themselves when they will be ready "*Then it's... well, when they feel that it's the right time, or that…they can't continue like that anymore*"$_{D5}$.

They are aware that patients do not tell them everything consciously by hiding their troubles "*in fact, they hide it… people hide it. So, we know that when they come in consultation they smell a little bit of alcohol regularly, we see it once, twice, three times, then we ask the question and... Despite, despite the breath, they don't confess*"$_{D2}$, because of shame "*alcoholism is poorly looked upon. There is someone who is going to say he's an alcoholic, it's always a matter of public image*"$_{D14}$ and guilt "*I don't discuss about it! No, I know it's weird, isn't it? But… I'm waiting for him to talk to me about it. I'm waiting for him to tell me, and then it's very difficult because we already put an label on them...*"$_{D9}$.

The professional can ask the question, but the patient is responsible of the answer and is the master of the disclosure "*it's rare for people to say "yes" when you tell them "do you drink every day?". Usually they tell you "no"."*$_{D1}$

FROM RESISTANCE TO CONFIDENCE

If patients are offered to project themselves in case they have an addiction, they describe a process that leads to awareness of the disorder: *"Weaning, well, it's already an awareness, to say it's not good for my health, then pregnancies, that's for sure part of it, and then, little by little, the fact of saying here I am quitting, I don't want to give this bad habit to my children, we take some distance, we don't smoke any more at home already, and then little by little we manage to get rid of it"*$_{P5}$.

Prevention messages and family contribute to become aware of this disorder: "*I started thinking about quitting smoking, during the campaign, so I was already thinking about it of course, there was the month without tobacco, a lot of things on TV, they were talking about it a lot, and then I said to myself, well, I was seeing people's testimonies and that also helped me to tell myself to stop*"$_{P15}$; *"if we go there as a couple, there often if the man doesn't speak, it can be the woman who explains the details of the evil, it's often like that in a couple"*$_{P10}$.

They believe that a trigger event, makes the person tip over into a process of care: *"I don't know, it's unfortunate to say, but I think that's what it took because his family, his wife was talking to him, advised him to stop, he didn't listen, well, he ended up in prison, he got an electroshocked to stop himself"*$_{P13}$.

In their projection, the professional they trust is the first person with whom to deal with their addiction: *"it's true that for me, it's first of all with my GP that I'll talk to him about these problems there, because he's someone who knows me, and I'd feel more reassured to talk about it to someone I know"*$_{P6}$ *; "I believe that the GP is important, precisely because he has contact with the patient, there is a stronger bond between the GP and the patient than with specialists, whom we see occasionally"*$_{P8}$. Independently of his speciality: *"it's a question of people really, open-mindedness, if you feel that the specialist, whatever the*

addiction, if he's open-minded, it's easier to go and express yourself and ask for things"$_{P12}$. An environment that guarantees confidentiality is important to them: *"But for my part, I wouldn't go to a pharmacy at all for this kind of thing, because it's already an open place, where there are several people, it's a bit like being in a shop, whereas with the GP you're alone with him, so for me that's how I feel it"*$_{P15}$ *; "I don't want to talk to the school nurse about it, I don't know if it's in the school file, but it has to do with teachers or school"*$_{P4}$.

For practitioners, the discovery of an addiction can be favored by several conditions.

They all reported the importance of time "*Well, we have to be honest about, depending on ... Well, I'll tell you, the main obstacle for me is actually time*"$_{D6}$, and availability "*it's mostly about time. We're busy... here we are. But like all general practitioners. We're taken up by time, we know there are people... and that's it*"$_{D5}$. It's difficult for doctors to approach the subject of addiction when they have to deal with many demands in one consultation "*I realized that I had never done it before, because there were always 50 things to deal with him in consultation*"$_{D13}$.

Issues like addictions need open attitude to trust "*I try to approach the situation, I try to approach the consultation as naturally as possible, I try to be close to the people, to use their language, their codes because it's the only way in my opinion to succeed in getting in touch with people (…) I like the part of the consultation when we go towards people and I think it's a moment where we establish a little more trust, proximity and then we can know at that moment, if people are going to tell things or not*"$_{D11}$. According to doctors, disclosure is facilitated by the patient's awareness of the disorder and its motivation to get helped "*the day she told me about it she said "I'd like to get treatment*""$_{D9}$ which passes through a personal click "*it was a real awareness, a personal click. Yeah. It was a click with... a strong motivating objective*"$_{D8}$.

TOGETHER OR NOTHING

People, expected person-centric relationship: "*we expect a particular listening and consideration of the person in a global way, not only of the physical effect"*$_{P5}$ *; "a doctor is not only... otherwise we would go to a computer, which would enter our symptoms, and then there would be a paper that would come out. So yeah, the relationship, trusting your doctor, he knows us as a whole, I think that's already a thing."*$_{P7}$ with listening and empathy, *"what we expect from a doctor is that he is listening and empathy"*$_{P15}$. They want someone who is a referrer and coordinates care *"I will first go to see my GP, who will refer me to colleagues who specialise in my addiction, because I don't know who to turn to first, so I will go first to my GP, and I will wait for him to refer me to a professional adapted for an addiction"*$_{P7}$.

Doctors expressed their powerlessness while facing resistance to disclosure and are frustrated that they cannot intervene earlier "*(his GP) had already proposed cures to him several times, and he was someone who never really wanted to do them. And ... even for him ... he's not even sure it will work in this ... The context of the person. But it's something that could have been… that could have been anticipated long before*"$_{D1}$. They have experience of situations where they feel they are not in the same temporality as the patient "*so when he comes it's anyhow, it's an emergency. It's always "everything's urgent" ... so no, no, no, it's a bit messy what he does*" $_{D9}$ or again "*When they come to see me, it means that it's... catastrophic*"$_{D3}$ They expect patients to be committed to the objectives set together "*we can... try to find other ways but there is a moment when it takes ... it takes two to dance a tango (…) That is to say, there is the doctor, the care provider, who participates in cares, and then the patient*"$_{D11}$

DISCUSSION

This original study highlighted the main elements underlying to success or failure of addiction screening. These elements made possible the conceptualization of difficulties concerning the early identification of addictions in primary care. Especially the need to recognise the role of health care providers by the patient, the common fear of talking about addictions, the importance of the first step, a patient's personal click to cross the red line and the right timing: a combination of multiple factors leading to unveiling and successful screening.

These results complement concepts already highlighted in previous studies, such as shared self-censorship, the personal click to cross a red line, as well as the disclosure that allows the identification of addiction[24-25]. All of these concepts could be associate in a theoretical model presented in *Figure 1*.

DUAL IDENTIFICATION

This study allows us to describe an early stage which is the pre-identification, where the patient and his doctor try to know the status and role of each other. On one side, patients do not feel directly concerned and overlook the preventive role of doctors, this fact was described in another study[26]. On the other side, the professional knows that the patient is not always aware of having a disorder, because of denial and lack of knowledge, these elements have already been revealed in a previous work [27].

Patients feel that the primary care provider is competent to take on this early identification role, although the doctor sometimes doubts of his technical skills. These doubts have also been described in other these on the subject [28].

Our work has allowed us to collect testimonies from doctors working in primary care centers and to have their experiences and opinions regarding their place in addiction's approach in their daily practice. Thus, we can differentiate environments that seem to favor disclosure, such as at the SIMPPS or the CeGIDD, where addiction is part of missions of these preventive medicine centers. In addition, doctors met in these centers said that they have a privileged relationship with addiction specialists due to their position. In contrast, interviews with occupational physicians revealed that their position did not favor transparency in patient discourse. However, the prevention of alcohol and drug use in the workplace was introduced in 2011 as a legal task for occupational health services[29]. We found few approaches to addictology in the context of planned parenthood center consultations, because the subject of gynecology seems to take up all the space and is the primary concern of consultants and doctors. This should be compared with studies involving more interviews with planned parenthood center's care providers.

SHARED SELF-CENSORSHIP

In this study we find again the concept of shared self-censorship already described[30]. On patient's side because of shame, guilt and the fear of being judged[31]. On doctors' side, our results corroborate the fact that some doctors find it difficult to ask the question because of various fears of moral judgements, not being competent, losing the follow-up which can disturb the doctor-patient relationship.[32]

Personal representations from care providers and the social stigma associated with addiction's trouble participate at the shared self-censorship.

Finally, patients report that they are aware of the censorship on the part of doctor, and that they understand it. They are even ready to share their intimacy, with the professional they have chosen, in order to improve their health.

EVERYONE'S WAITING FOR THE FIRST STEP: BANALISATION AND FRUSTRATION

Professionals and patients expect a first step from each other. Patients who don't have addictions imagine the fear of stigmatization that they could have, or the lack of motivation to change[33]. The patient sometimes expects the doctor to confront him with the truth, while the professional waits for the patient to become aware of his disorder, shows him that he is ready to take care of himself and waits for him to make the first move.[34]

Primary care providers, participate at a trivialization of the disorder, by discouragement, by omission, by time constraints and by perceptions of patients' truthfulness of information[35]. Feelings of powerlessness or of isolation in substances abuse management mentioned by doctors, and also found in many studies,[24] can be attenuated by better communication with care networks and multidisciplinary practices.[3]

All these factors contribute to the installation of a form of routine in the relationship between doctor and addict patients. Moreover, these elements reinforce the addict patient in his trouble, which leads to frustration on both sides.[36]

RED LINE & PERSONAL CLICK

Like in other descriptions, it has been found in our study that provision of prevention messages across media campaigns can produce positive changes or prevent negative changes in health-related behaviours across large populations[37-38]. The support from the patients' circle also allows them to become aware of their addictive disorder, and to enter into a virtuous process as described by Prochaska and Di Clemente [39-40]. The disclosure is not coming by the addition of problems related to addiction, but rather the crossing of a "red line", a key moment that belongs to the patient.[24]

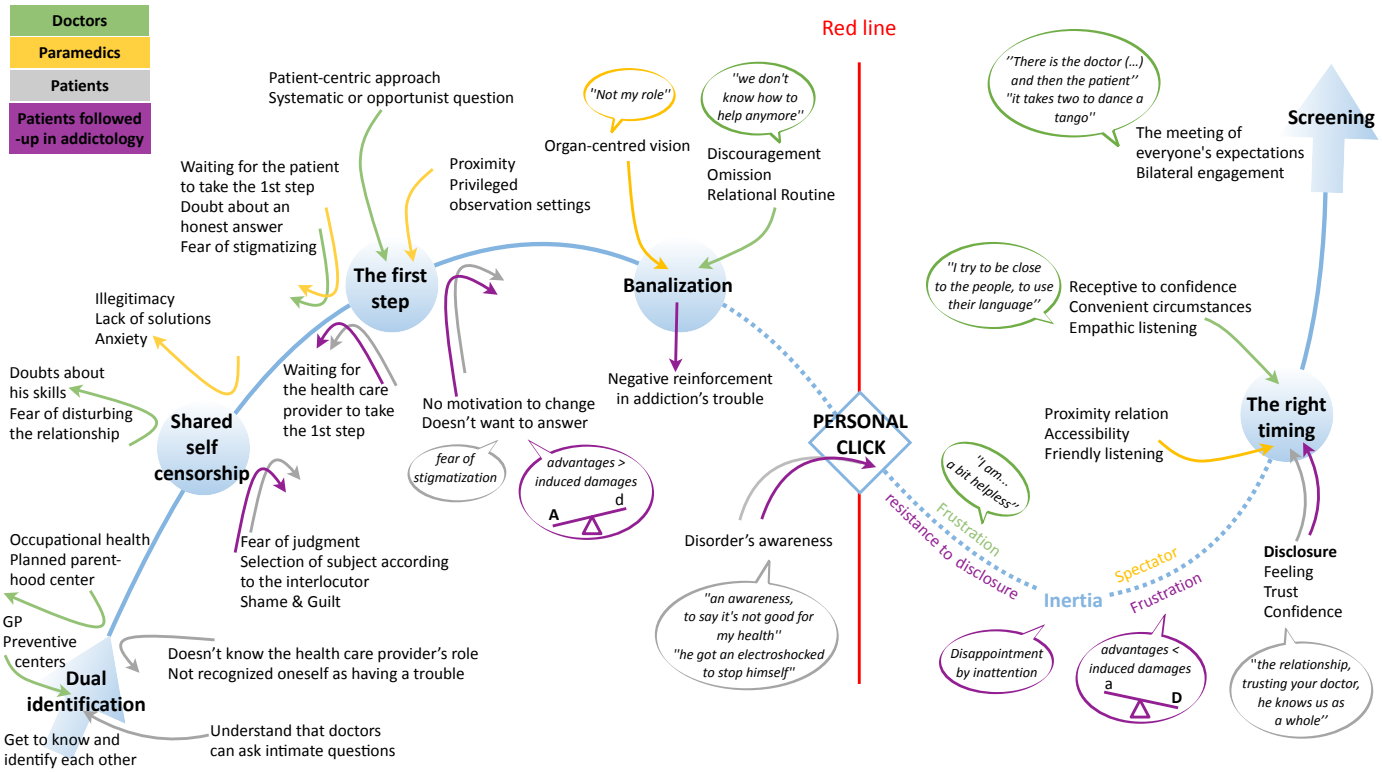
CATCH THE RIGHT TIMING

Our results allow us to understand what the patients expect in order to reveal themselves to professionals, it is a set of favourable conditions such as a person-centred vision, an empathic listening, a benevolent attitude, a clear and accessible information from the professional, as well as a confidential environment to guarantee medical secrecy.

Like in others studies[24,35] GPs emphasize that there are several circumstances that encourage the disclosure like the importance of attitudes, of communication, of personal motivation, which are favouring factors of confidence and disclosure.

The combination of these elements and the meeting of each person's expectations lead to the screening of the addiction and is the first step towards a therapeutic alliance.

Figure 1.



Strengths and limits of the study

The choice of a grounded theorization analysis was justified by the search for the conceptualization of patients' and doctors' crossed experiences[41]. The COREQ criteria *(Table 3)* for grounded theorizing research were respected at each work step. This type of analysis exposes to interpretation and confirmation bias[42]. The initial distance between preconceived ideas, the strictly inductive analysis and the triangulation of data allowed to limit the influence of investigators' subjectivity. The reasoned sampling of the study, even if limited, provided the diversity necessary for data sufficiency. Semi structural interviews were chosen to eliciting individual experiences, addressing sensitive topics, get depth responses with nuances and contradictions and get an interpretive perspective. This study proposes a social theory for the identification of addictions, sometimes based on elements already known in literature. In this case, patients who do not have problematic drug use sometimes have a naïve view of the reality of dependence, but this point of view is also a strength of this study, because it highlights the crucial role of primary care providers. Achieving a quality empathic patient-centred relationship is a prerequisite for the identification of addictive disorders, much more sought-after than technical skills or a self-administered questionnaire screening, enabling to remove doubts of professionals about their main function.

Perspectives

This qualitative study explored the experience of screening addictions through the eyes of primary care physicians and patients. It complements previous studies and enriches a panorama of points of view of different actors on the subject. The outcome to a complete well-grounded theorization allows an awareness of the realities of the field and helps to learn from the different obstacles, with perspectives of:

- finding ways of positively influencing the motivational factors to engage health care providers in substance abuse management
- establishing devices to encourage our patients to disclose their health condition
- achieving the construction of a tool to help daily practice

Parameters to be taken into account in order to improve early screening.

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Appendix 1: guide d'entretien initial, population générale

Je m'appelle Justine Minet, interne de médecine générale à Tours. Mon sujet de thèse s'intéresse aux réalités du repérage en soins primaires des conduites et consommations problématique et addictions. Elle s'inscrit dans le cadre d'un projet plus vaste, PAPRICA (Problematic use and Addiction in Primary Care), dont le but est de d'identifier les problèmes rencontrés dans le repérage des addictions et consommations problématiques et d'y apporter des solutions. Il s'agit d'une étude qualitative issue d'entretiens avec des personnes consultant des professionnels de santé dans différentes régions. Cet entretien est enregistré et anonyme. Il sera ensuite retranscrit par écrit pour être analysé selon la méthode par théorisation ancrée.

Questions « brise-glace »

- Racontez-moi la dernière fois qu'un médecin ou un autre professionnel de santé vous a déjà posé une question qui vous a surprise, étonnée, à laquelle vous ne vous attendiez pas.

Repérage

- Les professionnels de santé peuvent être amenés à poser des questions sur pleins de sujets intimes comme les addictions (pour mémoire : alcool, tabac, drogues, jeux de hasard, PMU, loto) : vous en pensez quoi ?
  Si ne dit rien :
- Qu'en pensez-vous ? Est-ce leur rôle ?
- Avez-vous déjà répondu à ce type de questions ? Racontez-nous comment ça s'est passé. Comment vous êtes-vous sentis ? Est-ce que ça a changé vos habitudes, votre façon de voir les choses ?
- Si non : Est-ce que vous répondriez à ce type de questions ? en quoi cela serait difficile ?

Les drogues et les professionnels de santé

- Si vous aviez des problèmes de drogues ou de dépendance, vous en parleriez à qui d'une manière générale ? A partir de quand vous estimeriez avoir besoin d'aide ? Est-ce que vous iriez en parler à votre médecin généraliste ? Pourquoi ?
- Est-ce que vous pensez que pour un professionnel de santé c'est difficile d'aborder ces sujets ? pourquoi ? Est-ce que vous pensez que pour vous se serez difficile d'en parler/d'y répondre ?

La représentation des professionnels de santé

- A titre personnel, avez-vous déjà connu un problème d'addiction ?
- Quel rôle a pu jouer le professionnel de santé dans cette situation ? Comment peut-il aider ? vous prescrire des médicaments ? vous adressez à une autre personne ?
- Connaissez-vous le rôle des addictologues ? Qu'en pensez-vous ?
- Si vous n'avez pas été concernés mais en avez entendu parler : qu'en n'ont dit les gens ? si vous aviez proche concerné, qu'attendriez-vous du médecin ? que feriez-vous ?

Appendix 2: guide d'entretien initial, médecins de soins primaires

Je m'appelle Sérenna Sen, interne de médecine générale à Tours. Mon sujet de thèse s'intéresse aux réalités du repérage en soins primaires des conduites et consommations problématiques et additions. Elle s'inscrit dans le cadre d'un projet plus vaste, PAPRICA (Problematic use and Addiction in Primary Care), dont le but est d'identifier les problèmes rencontrés dans le repérage des addictions et consommations problématiques et d'y apporter des éléments de réponses. Il s'agit d'une étude qualitative issue d'entretiens avec des acteurs de soins primaires de différentes régions.

Cet entretien est enregistré et anonyme. Il sera ensuite retranscrit par écrit pour être analysé selon la méthode par théorisation ancrée.

Question « brise-glace »

- Pouvez-vous me raconter la dernière consultation vécue avec un patient suivi pour addiction ?
- Comment le sujet a t'il été abordé la première fois ? Quel était le motif de sa venue ?
- Quelles difficultés ou facilités avez-vous éprouvés lors de cette situation ?

Repérages ratés

- Pouvez-vous me raconter l'histoire d'un patient pour lequel vous avez l'impression d'être passé à côté de son problème d'addiction ?
- D'après vous, pourquoi ça a raté ?
- Qu'est-ce qui aurait pu être amélioré dans son repérage ?

Repérages réussis

- Racontez-moi maintenant l'histoire d'un repérage qui s'est bien passé ?
- Quels sont les éléments qui ont facilité cette situation ?
- Quelle était la circonstance/situation de découverte la première fois ?

Addictologie

- Que pensez-vous des médecins addictologues ?
- A votre avis qu'attendent les addictologues des professionnels de premiers recours ?
- Quels freins entre ces spécialités voyez-vous ?

A votre avis, que faudrait-il faire pour améliorer le repérage en soins primaires ?

Appendix 3:

LETTRE D'INFORMATION DE LA RECHERCHE

Version n°1 du 28/05/2018

Acronyme :

Etude PAPRICA : Problematic use and Addiction in Primary Care

Promoteur de la recherche :

CHRU de Tours - 2, boulevard Tonnellé 37044 Tours Cedex 9

Investigateur coordonnateur :

Dr PAUTRAT Maxime

Médecin Généraliste – Chef de Clinique universitaire de médecine générale

CHRU de Tours - 2, boulevard Tonnellé 37044 Tours Cedex 9

Téléphone : 02 18 08 20 00

Madame, Monsieur,

Vous avez été invité(e) à participer à une recherche organisée par le CHRU de Tours et appelée PAPRICA.

Cette recherche dite non interventionnelle ne comporte aucun risque ni contrainte pour vous. Le fait de participer à cette recherche ne changera donc pas votre prise en charge. Néanmoins, en l'absence d'opposition, un traitement de vos données de santé pourra être mise en œuvre.

Prenez le temps de lire les informations contenues dans ce document et de poser toutes les questions qui vous sembleront utiles à sa bonne compréhension. Vous pouvez prendre le temps nécessaire pour décider si vous souhaitez vous opposer à ce que les données qui vous concernent soient utilisées dans le cadre de cette recherche.

QUEL EST L'OBJECTIF DE CETTE ÉTUDE ?

Explorer la pratique du repérage des conduites et consommations problématiques et polydépendance en soins primaires.

Votre médecin généraliste est amené à repérer et aider des personnes ayant des problèmes de dépendances. Même si vous n'êtes pas concerné, nous cherchons à connaitre votre avis : pensez-vous que c'est son rôle ? Seriez-vous surpris qu'il vous pose la question ? Si vous aviez des problèmes de dépendances, en parleriez-vous à votre généraliste ?

QUE SE PASSERA T'IL SI JE PARTICIPE À LA RECHERCHE ?

Si vous ne vous opposez pas à participer à cette recherche, les données vous concernant seront recueillies et traitées afin de répondre à l'objectif mentionné plus haut.

Votre participation durera le temps de cet entretien et il n'y aura ni visite ni examen supplémentaire par rapport à votre suivi habituel.

EST-CE QUE JE PEUX RENONCER A MA PARTICIPATION ?

Votre participation est entièrement volontaire. Vous êtes donc libre de changer d'avis à tout moment et de vous opposer, sans avoir à vous justifier, au traitement de vos données dans le cadre de cette recherche. Votre décision n'aura aucune conséquence sur votre prise en charge.

Dans ce cas, vous devrez avertir le coordonnateur de cette recherche ou le médecin qui vous a proposé d'y participer. Ce dernier s'engage alors à communiquer votre opposition au Promoteur.

EST-CE QUE MA PARTICIPATION RESTERA CONFIDENTIELLE ?

Dans le cadre de cette recherche, un traitement informatique de vos données de santé va être mis en œuvre pour permettre d'analyser les résultats de la recherche au regard de l'objectif qui vous a été présenté. Ces données pourront également, dans des conditions assurant leur confidentialité, être transmises au Promoteur ou aux personnes agissant pour son compte. Ces données seront donc identifiées par un code et les initiales de votre nom et prénom.

Conformément aux dispositions de la loi relative à l'informatique, aux fichiers et aux libertés, vous disposez à tout moment d'un droit d'accès et de rectification des données informatisées vous concernant (loi n° 2004-801 du 6 août 2004 modifiant la loi n° 78-17 du 6 janvier 1978 relative à l'informatique, aux fichiers et aux libertés). Vous disposez également d'un droit d'opposition à la transmission des données couvertes par le secret professionnel susceptibles d'être utilisées dans le cadre de cette recherche et d'être traitées. Vous pouvez accéder directement ou par l'intermédiaire du médecin de votre choix à l'ensemble de vos données médicales en application des dispositions de l'article L1111-7 du code de la santé publique. Ces droits s'exercent auprès du médecin qui vous suit dans le cadre de la recherche et qui connaît votre identité.

QUI A APPROUVÉ LA RECHERCHE ?

En application des dispositions de l'article L1121-4 du code de la santé publique, les modalités de cette recherche ont été soumises à un Comité de Protection des Personnes (CPP) qui a notamment pour mission de vérifier les conditions requises pour la protection et le respect de vos droits. Le CPP a donné un avis favorable.

QUI POURRAI-JE CONTACTER SI J'AI DES QUESTIONS ?

Le médecin qui vous a proposé cette recherche est à votre disposition pour vous fournir toutes informations complémentaires. Si vous le souhaitez, vous pouvez contacter directement le coordonnateur de cette recherche : le Dr PAUTRAT (02 18 08 20 00)

A compléter par l'investigateur (médecin ou personne qualifiée)

Nom, prénom investigateur *:* .....

N° de téléphone : |___|___|-|___|___|-|___|___|-|___|___|-|___|___|

Nom, prénom de la personne qui se prête à la recherche : .....

Date de délivrance de l'information : ___ / ___ / _____ Opposition exprimée : ☐ **Oui** ☐ **Non**

Signature investigateur :

A compléter en 2 exemplaires : le 1er exemplaire est à conserver par l'investigateur, le 2nd par le patient

FORMULAIRE D'OPPOSITION
A L'UTILISATION DES DONNEES DE SANTE POUR LA RECHERCHE

Etude Acronyme :

Etude PAPRICA : Problematic use and Addiction in Primary Care

Promoteur de la recherche :

CHRU de Tours - 2, boulevard Tonnellé 37044 Tours Cedex 9

Investigateur coordonnateur :

Dr PAUTRAT Maxime

Médecin Généraliste – Chef de Clinique universitaire de médecine générale

CHRU de Tours - 2, boulevard Tonnellé 37044 Tours Cedex 9

Téléphone : 02 18 08 20 00

A compléter par la personne qui se prête à la recherche uniquement en cas d'opposition

Coordonnées de la personne se prêtant à la recherche :

Nom : ……

Prénom : ……

☐ **Je m'oppose à l'utilisation de mes données de santé dans le cadre de cette recherche**.

☐ **Le cas échéant, je m'oppose à l'utilisation de toutes les données recueillies antérieurement.**

Vous pouvez à tout moment revenir sur votre décision, il vous suffit de prévenir le coordonnateur de cette recherche ou le médecin qui vous a proposé d'y participer.

Date : ___ / ___ / _____ *Signature :*

Après avoir complété ce document, merci de le remettre au qui vous a proposé de participer ou directement au coordonnateur de la recherche.

Appendix 4: Avis favorable du comité d'éthique

GROUPE ETHIQUE D'AIDE A LA RECHERCHE CLINIQUE POUR LES PROTOCOLES DE RECHERCHE NON SOUMIS AU COMITE DE PROTECTION DES PERSONNES
ETHICS COMMITTEE IN HUMAN RESEARCH

AVIS

Responsable de la recherche : Dr Maxime PAUTRAT
Titre du projet de recherche : Etude PAPRICA : Problematic use and Addiction in Primary Care
N° du projet : 2017 059

Le groupe éthique d'aide à la recherche clinique donne un avis

X **FAVORABLE**
Sous réserve d'une déclaration à la CNIL

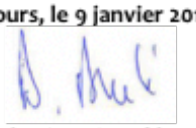
☐ **DÉFAVORABLE**

☐ **SURSIS A STATUER**

☐ **DÉCLARATION D'INCOMPÉTENCE**

au projet de recherche n° 2017 059

A Tours, le 9 janvier 2018



Dr Béatrice Birmelé
Directrice ERERC

2, Bd Tonnelé - 37044 TOURS Cedex 9 – Tél. 02.18.37.08.50
Courriel : espace-ethique@chu-tours.fr

Appendix 5: Enregistrement à la CNIL

C.H.R.U. TOURS
Pôle Finances, Facturation, Système d'Information
Correspondant Informatique et Libertés

09/04/2018

Traitements mis en œuvre au sein du C.H.R.U. de Tours

Pour aller à la ligne à l'intérieur d'une cellule : combinaison de touches : [Alt] + [Entrée]

Date de déclaration :	29/06/2017	
Nom du traitement :	PAPRICA - Problematic use and Addiction in Primary Care	
Type de recherche		
Avis du CPP ou CEREES		
Document de référence CNIL :	MR-003	
Date de mise en oeuvre:	2017-2019	
Finalité principale:	Etablir une théorie sociale du repérage des addictions en soins primaires = étude de pratique	
Type de déclaration :	Engagement de conformité	
Pôle : **Service chargé de la mise en œuvre :**	Médecine générale DUMG Tours	
Personne chargée de la mise en œuvre :	Dr Maxime PAUTRAT - médecin généraliste MSP Liguel & CCU MG Tours	
Personne référente de ce dossier au service infomatique :		
Contact CNIL :	Eric TRIPAULT Pôle Finances, Facturation, Système d'Information 2 Boulevard Tonnellé 37044 TOURS CEDEX 9 Tel : 02 47 47 84 46 Email : cil@chu-tours.fr ou e.tripault@chu-tours.fr	
Catégories de personnes concernées par le traitement :	Entretien auprès 1) de patients suivi en addictologie, 2) de patients suivi en médecine générale 3) de médecins addictologues 4) de médecins généralistes	
Catégories de données traitées :	Entretiens individuels et en groupe, enregistrés, retranscrits et anonymisés. Données déclaratives : données d'identification (nom, prénoms, sexe, profession, lieu d'exercice,...)	
Catégories de destinataires:	**Destinataires : Données concernées**	
	Médecins chercheurs : Ensemble des données	
	Sujets d'étude : Résultats issus de leur entretien	
	Revues scientifiques : Résultats principaux	
Durée de conservation:	**Données**	**Durée de conservation**
	Entretiens individuels et en groupe, enregistrés, retranscrits et anonymisés. Données déclaratives : données d'identification (nom, prénoms, sexe, profession, lieu d'exercice,...)	Pour le chercheur jusqu'à publication
Mise à jour (date et objet):	29/06/2017	
Nom / Prénom du déclarant :	Dr Maxime PAUTRAT - Chef de Clinique Universitaire	
Signature du déclarant (en cas de déclaration papier) :		

N° d'enregistrement C.H.R.U. (à remplir par le contact CNIL) :	2017_093 v 0
N° d'enregistrement CNIL :	0

Document à envoyer à : cil@chu-tours.fr

2017_093 v 0 PAPRICA - Problematic use and Addiction in Primary Care Fiche recensement 1/1

Table 1: table of participants' characteristics (Patients)

	Gender, age	Profession	Place	Family Statue	Problematic use felt	Professional meet before the interview	Medical follow-up by the GP in years	GP's specific practice	ITW time (min)
P1	27, H	mechanic	Loches	Single	no	osteopath	10	Sports physician	7
P2	54, H	Public service manager	Loches	Maried	Tabacco stop	GP	35	None	19
P3	19, H	student	Pornic	Single	screens	School nurse	19	none	8
P4	19, F	student	Pornic	Single	no	School nurse	19	none	9
P5	56, F	teacher	Pornic	Divorced	Tabacco stop	School nurse	20	none	23
P6	32, F	unemployed	Loches	Maried	no	Midwife	10	tobaccologist	13
P7	35, H	engineer	Loches	Maried	no	Midwife	30	none	36
P8	81, F	pensioner, *housewife*	Etaules	Maried	no	pharmacy	5	homeopath	11
P9	80, H	pensioner, *railwayman*	Etaules	Maried	Tabacco stop	pharmacy	20	none	14
P10	70, F	Pensioner, *puericultrice*	Tours	Maried	no	pharmacy	30	none	15
P11	73, H	Pensioner, *printer*	Tours	Maried	no	pharmacy	30	none	14
P12	38, H	unemployed	Bordeaux	Couple	no	GP	38	Sports physician	29
P13	42, H	secretary	Bordeaux	Divorced	no	GP	10	none	16
P14	41, F	Aeronautic worker	Bordeaux	Couple	Tabacco stop	GP	3	none	11
P15	28, F	educator	Bordeaux	Couple	Tabacco stop	GP	28	none	26

Table 2: table of participants' characteristics (Doctors)

	Gender, age, type of work	Duration of installation / replacement	Place of practice	Consultation/ hour	Socio-economic level and age profile of patients	Speciality (University Diploma, Capacity)	Training in addictology / attraction to addictology	Link with addictive behaviours	Interview time (minutes)
D1	W, 40, medical practice	Replacent since 6 months	Rural, Centre-Val de Loire	4	. Average socio-economic level . Middle-aged population	None	. No training . Attraction	yes close entourage	34
D2	M, 34, medical practice	Installed since 6 months	Rural, Centre-Val de Loire	4	. Average socio-economic level . Elderly population	None	. No training . Attraction	No	31
D3	M, 58, medical practice	15 years in rural areas and 4 years in urban areas	Urban, Centre-Val de Loire	3	. Average socio-economic level . Elderly population	. Geriatric capacity . Sports Medicine capacity	. No training . No attraction	yes close entourage	42
D4	W, 61, medical practice	Installed since 26 years	Urban, Centre-Val de Loire	4	. Average socio-economic level . Middle-aged population	. UD Medical expertise . UD Acupuncture . UD Homeopathy	. Training on tobacco . Attraction	No	27
D5	W, 55, university prevention center	Since 20 years	Urban, Bretagne	4	. Average socio-economic level . Young population	. UD Nutrition . UD Addictology	. Training (UD Addictology) . Attraction	yes close entourage	28
D6	W, 35, university prevention center	Since 2 years	Urban, Bretagne	3	. Average socio-economic level . Young population	None	. Training during internship . Attraction	yes close entourage	48
D7	W, 31, free testing center for sexually transmitted diseases	Since 1 year	Urban, Ille-de-France	5	. Low socio-economic level . Young population	None	. No training . Attraction	No	17
D8	M, 40, occupational physician	Since 2 years	Rural and Urban, Centre-Val de Loire	2	. Average socio-economic level . Young and middle-aged population	. UD tropical medicine . UD Epidemiology	. Addiction training in occupational medicine . No attraction	No	36
D9	W, 36, medical practice	Installed since 4 years	Urban, Bretagne	3-4	. Low socio-economic level . Young population	None	. No training . No attraction	No	43
D10	W, 33, planned parenthood center	Since 6 years	Urban, Bretagne	2-3	. Average socio-economic level . Young population	. UD Gyneco-obstetric . UD Violence against women . UD Hypnosis	. No training . No attraction	No	36
D11	M, 50, medical practice	Installed since 19 years	Rural, Bretagne	3	. Average socio-economic level . Middle-aged population	None	. No training . No attraction	Yes personally	58
D12	W, 60, occupational physician	Installed since 25 years	Urban, Bretagne	2-3	. Average socio-economic level . Young population	. UD Sports Medicine . UD Agricultural medicine . UD Mother-child protection	. Continuing education . No attraction	No	34
D13	M, 29, medical practice	Installed since 1 year	Urban, Bretagne	3	. Average socio-economic level . Young population	None	. Training during internship . Attraction	No	41
D14	M, 63, medical practice	Installed since 30 years	Rural, Bretagne	2-3	. Low socio-economic level . Middle-aged population	. UD Gyneco-obstétric . UD Nutrition	. No training . No attraction	No	54

Table 3: Grille COREQ

	Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist		
No.	Item	Guide questions/description	Response/page number referenced
	Domain 1: Research team and reflectivity		
	Personal characteristics		
1	Interviewer/facilitator	Which author/s conducted the interview?	For patients : page 29 (guide d'entretien) All performed by the same investigator (JM), a MD student of general medicine For doctors: page 30 (guide d'entretien) All performed by the same investigator (SS), a MD student of general medicine
2	Credentials	What were the researcher's credentials? E.g. PhD, MD	J. MINET : student of general medicine S. SEN : student of general medicine M. PAUTRAT : senior registrar, GP MD, Msc
3	Occupation	What was their occupation at the time of the study?	Author statement as above
4	Gender	Was the researcher male or female?	Not relevant in the context of this study as would not have affected participant's conduct or analysis of semi-structured interviews
5	Experience and training	What experience or training did researchers have?	J. MINET & S. SEN : GP students M. PAUTRAT : involved in data collection and analysis had conducted and been involved in prior qualitative research studies
	Relationship with participants		
6	Relationship established	Was a relationship established prior to study commencement?	No relationship between investigators and participants page 14
7	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	Pages 29 & 30 (Patient recrutement section/Guide d'entretien): investigators (JM & SS), MD students of general medicine without any connection to any of the participants Pages 31-33: Participants were also given a brief background to the rationale of the study when they signed the informed consent.
8	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Page 24 (discussion section): bias of subjectivity Reasons and interest in the topic area reported on Page 13 (background section): "Identifying these behaviours in primary care is effective, but insufficiently carried out"
	Domain 2: study design		
	Theoretical framework		
9	Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Pages 14-15 (method, analysis) "Categories were built from the initial coding using the same triangulation procedure. This inductive analysis allowed to describe some concepts"
	Participant selection		
10	Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	Page 14 (patient recruitment): reasoned samples were based on predefined criteria by convenience and consecutive
11	Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	Page 14 (design): patients were recruited in waiting rooms of health care professionals Doctors were recruited by e-mail, telephone or on the spot
12	Sample size	How many participants were in the study?	Pages 36 & 37 : Tables 1 & 2
13	Non-participation	How many people refused to participate or dropped out? Reasons?	Not applicable- All who registered interest took part in the interviews

	Settings		
14	Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	Page 14 (population): primary care provider office and waiting room of professionals
15	Presence of non-participants	Was anyone else present besides the participants and researchers?	no other persons present during conduct of interviews
16	Description of sample	What are the important characteristics of the sample?	Pages 36 & 37 (participant characteristics): Table 1 & 2
	Data collection		
17	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	Interview guides provided by the authors It was not pilot tested
18	Repeat interviews	Were repeat interviews carried out? If yes, how many?	15 for patients 14 for doctors
19	Audio/visual recording	Did the research use audio or visual recording to collect the data?	Page 14 (data collection) "The interviews were recorded, transcribed verbatim, and anonymized."
20	Field notes	Were field notes made during and/or after the interview or focus group?	Field notes were taken to provide information on the interview environment
21	Duration	What was the duration of the interviews or focus group?	Pages 36 & 37 : Tables 1 & 2
22	Data saturation	Was data saturation discussed?	Page 14: "reasoned samples were based on predefined criteria to obtain the global variety"
23	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	Not applicable as transcripts were not returned to participants.
	Domain 3: analysis and findings		
	Data analysis		
24	Number of data coders	How many data coders coded the data?	Three investigators of the study
25	Description of the coding tree	Did authors provide a description of the coding tree?	Not necessary in this study
26	Derivation of themes	Were themes identified in advance or derived from the data?	Coders not defined what would be considered a significant theme prior to data analysis
27	Software	What software, if applicable, was used to manage the data?	NVivo release 1.2.3
28	Participant checking	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number.	Pages 16-20 (results section): Quotations are presented throughout the text alongside interpretations.
	Reporting		
29	Quotations presented	Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. participant number	Pages 16-20 (results section): Quotations are presented throughout the text alongside interpretations
30	Data and findings consistent	Was there consistency between the data presented and the findings?	Pages 16-20 (results section): Quotations are presented alongside interpretations for transparency between data and findings.
31	Clarity of major themes	Were major themes clearly presented in the findings?	Pages 16-20 (results section) and pages 22-24 (discussion section): results have been presented by the most symbolic quotations and have been organized by themes
32	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	Pages 22-24 : the discussion gives meaning to the most significant results

Vu, le Directeur de Thèse

Vu, le Doyen
De la Faculté de Médecine de Tours
Tours, le

MINET Justine
SEN Sérenna

42 pages – 3 tableaux

RESUME

Introduction : Les conduites addictives entrainent une morbi-mortalité importante, et un coût social majeur. Un repérage précoce de ces comportements en soins primaires est nécessaire, mais insuffisamment réalisé malgré les recommandations internationales. L'objectif de cette étude était de croiser les points de vue de médecins de soins premiers et de patients sur leurs expériences vécues et leurs attentes vis-à-vis du repérage afin d'en comprendre les difficultés.

Matériel et Méthode : Deux études qualitatives, multicentriques ont été menées aux cours d'entretiens individuels semi-dirigés, auprès d'un échantillon raisonné de médecins de soins primaires et de patients consultants des professionnels de santé. Les entretiens ont été enregistrés, anonymisés, retranscris, et analysés selon la méthode de théorisation ancrée.

Résultats : Quatorze médecins et quinze patients ont été interrogés. Médecins et patients décrivaient une première étape de pré-repérage, dans laquelle le médecin dépistait un patient avec un usage problématique, avec, en parallèle un patient qui se reconnaissait avoir un trouble et identifiait un professionnel potentiellement source d'aide dans sa prise en charge. Parler d'addiction nécessitait de s'affranchir de ses représentations et de ses craintes, avec d'un côté pour les médecins la peur de perturber la relation et de ne pas être compétent, et d'un autre côté la peur du jugement ressentie par les patients. Le dévoilement des patients, comme levée de ces obstacles, était conditionné par un ensemble de facteurs favorisants. Enfin, le repérage était décrit comme une rencontre entre les attentes de chacun permettant d'initier le changement.

Discussion : La conceptualisation obtenue par l'analyse croisée des discours de médecins et de patients a permis de souligner les convergences et divergences des points de vue de chacun, et d'apporter des éléments de réponses en ce qui concerne les conditions amenant au dévoilement et au repérage des troubles addictifs des patients. Elle vient compléter des études antérieures et enrichir un panorama de points de vue des différents acteurs sur le sujet. L'aboutissement à une théorisation ancrée complète permet une prise de conscience des réalités du terrain, d'apprendre à partir des points de blocage, avec la perspective de construire des outils d'aide à la pratique quotidienne, dans le but d'améliorer le repérage précoce.

Mots clés : *addiction, repérage, soins primaires, étude qualitative.*

Jury :

Président du Jury :	Professeur Jean-Pierre LEBEAU
Directeur de thèse :	Docteur Maxime PAUTRAT
Membres du Jury :	Professeur Nicolas BALLON
	Professeur Emmanuel RUSCH

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