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Alcohol - a public health problem. Is there a role for the general practitioner?

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There is little doubt that alcohol is a public health problem. The relationship between excessive consumption and physical, psychological and social consequences is well documented. For example, research in Edinburgh and Hull[1] suggests that one in six accidents in emergency cases is alcohol-related. That is one every 15 seconds. Industry loses between 8 and 14 million days work due to absenteeism following heavy drinking. The Home Office estimates that 45% of violent crime is committed by people who have been drinking. The physical harms caused by alcohol are extensive and it is thought that one in five men admitted to hospital have an alcohol-related problem[2]. The most common indices used to show the relationship between alcohol consumption and physical harm is liver cirrhosis. Figure 1[3] shows that since the mid 1940s the rate of other liver disease has remained fairly constant whereas deaths from liver cirrhosis have increased. This increase is in line with alcohol consumption. As consumption in this country has increased so have the risks of ill-health and death associated with alcohol consumption. There is a direct correlation between reduction in the price of alcohol and increases in consumption, death rate and harm. Furthermore, heavy alcohol consumption may be associated with an increased incidence of cancer of the colon and rectum. Heavy consumption also increases the risk of cancer of the mouth and pharynx 3-fold, larynx 4-fold and oesophagus 2-fold[4]. There is now considerable evidence to support the relationship between moderate drinking and a rise in systolic and diastolic pressure[5] (Figure 2).

It has been suggested that for one in nine patients who are hypertensive, alcohol may be the direct cause[6]. Raised blood pressure is recognized as being associated with strokes and in young adults the occurrence of strokes is associated with heavy bouts of drinking[7].

The relationship between breast cancer and alcohol consumption has been studied in the USA for a number of years. Two independent studies by Schatzkin[8] and Willett[9] show a correlation between alcohol consumption and breast cancer after controlling for age, race, education, smoking, body mass index, nutritional status and reproductive factors. Longnecker[10] in a meta analysis of all the studies done on alcohol and breast cancer confirms that there is strong evidence to support a dose-response relationship.

Alcohol accounts for one third of home accidents and it is the single most common factor in death by drowning. Heavy drinkers have an accident rate at work three times higher than normal. From 1973 to 1984, 143 children aged 0-14 years were seen in the A & E department of Glasgow and Nottingham hospitals[11]. Fifty-three children were aged under 7 years and had accidentally obtained alcohol either

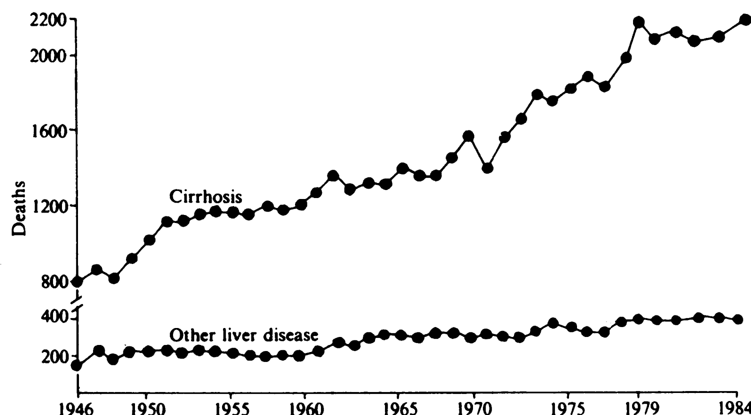

Figure 1. Deaths from cirrhosis and other liver disease in England and Wales (Source: OPCS Morbidity Statistics[3])

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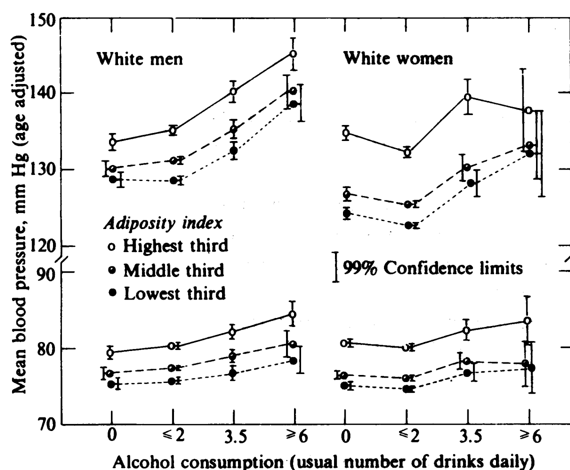

Figure 2. Blood pressure related to alcohol consumption (reprinted from Klatsky[5] by permission of N Engl J Med)

after a social event in the home the previous night or from easily accessible places. Alcohol is another substance to be added to the long list of dangerous substances in the home (eg bleach, medication) that should be secured away from children, and should be included in advice on home safety.

There is also a relationship between alcohol use and acquired immunodeficiency syndrome (AIDS). Misuse of alcohol is related to risk taking, disinhibition and lack of self-care, and these types of behaviour are associated with the risk of contracting AIDS. Stall *et al.*[12] found a strong relationship between the use of drugs and/or alcohol during sexual activity and non-compliance with safety techniques. AIDS prevention programmes need to take into account the complex relationships between alcohol and drug misuse and sexual activity.

Alcohol use and misuse is frequently associated with psychological and social harm. The long list of harms include child neglect and abuse, wife battering, violence, crime, hooliganism, marital conflicts, divorce and homelessness. But problems associated with alcohol are not restricted to the dependent drinker. The majority of drinkers who cause the biggest public health problem are moderate and heavy drinkers. It is giving advice to this group that is likely to reduce the physical, psychological and social harms in this country today.

The three Royal Colleges have recognized the role that doctors have in reducing this public health problem and have all produced reports making similar recommendations.

Priority for prevention
'Health policies on alcohol problems should give much greater attention than have previously been the case'[13].

Emphasis on doctor's responsibility
Asking patients about alcohol and recording consumption should become a normal part of the health care process[14].

Coordinated governmental help
(a) More stringent enforcement of the drink driving laws.
(b) Formation of a single governmental body to coordinate all aspects of alcohol use and abuse[15].

The Royal College of General Practitioners report *Alcohol: A Balanced View*[14] suggested recommendations including:

(1) To encourage general practitioners to assess and record the consumption of alcohol for all their patients.
(2) To assist general practitioners in the task of informing and advising patients about reduction in alcohol consumption.
(3) To promote teamwork between professional and lay colleagues both within practice and in wider local communities.

General practitioners and members of the primary health care team are in a unique position for promoting health. One million people come to a GP each day and more than 90% of patients consult a GP in a 5-year period. In 1983 the Consumer Association General Health Survey[16] asked about sources of reliable health information. Ninety-five per cent of the respondents trusted the message put over by GPs and 87% of the respondents trusted a nurse. It is therefore essential that professionals are not seen to collude with patients on their alcohol consumption and that health education messages put over are factually correct and consistant. Wallace and Haines[17] using a postal survey of 2572 patients showed that four-fifths of patients believed that their GP should be interested in their drinking problem and two-fifths believed that their GP was interested. This lack of interest shown by GPs may be because they found it difficult to ask patients about alcohol consumption rather than they do not feel they had a role. However, heavy drinkers consult their GPs twice as often as light drinkers and are therefore costing the general practitioner a lot of time and money. In order for a general practitioner to reduce the consultation time used by heavy drinkers they could give health education advice to patients who have excessive alcohol consumption. Wallace *et al.*[18] looked at the effectiveness of advice from GPs to heavy drinkers to reduce their excessive alcohol consumption. Heavy drinkers were categorized as: 35 units plus for men and 21 units plus for women. Patients in the treatment group (448 patients) were interviewed by the GPs and received information on alcohol and a drinking diary. After one year the results showed that 43.7% of the treatment group had reduced their alcohol consumption and of the control group (total 436) 25.5% had reduced their alcohol consumption. Thus general practitioners are effective in assisting excessive drinkers to reduce their alcohol consumption.

In the early 1980s the Oxford Prevention of Heart Attack and Stroke Project was set up. Its aim was to assist general practices to identify and screen for risk factors in patients health. The person who would assist the general practices was called a 'facilitator'. However, during audits of samples of practice notes it was noted that recordings of alcohol consumption were minimal compared to recordings on smoking, blood pressure etc. Therefore, in 1986 the Alcohol Project in General Practice was set up in Oxford. The facilitator in this project encourages nurses and GPs to ask about alcohol consumption, opportunistically, during a consultation, during a health check or when a patient registers. Nurses and GPs are encouraged to give advice, patient literature and follow-up support to those patients who are moderate or heavy drinkers. The literature specifically used for patients at risk is called the 'Cut Down on Drinking' Kit[19]. This material is not intended for the management of patients who already have been severely damaged by alcohol.

Table 1. Levels of risk

Risk	*Women*	*Men*
Low	Less than 15 units per week	Less than 20 units per week
Moderate or intermediate	15-35 units per week	20-50 units per week
High	36 units per week or more	51 units per week or more

Asking a patient about his or her weekly alcohol intake may at first feel difficult but it is as appropriate as asking about all aspects of their lifestyle for example, cigarette smoking and diet. The amount of alcohol should be recorded in units per week. The Royal Colleges of General Practitioners, Physicians, and Psychiatrists made recommendations for personal risk at different levels of alcohol consumption (Table 1)[14].

Drinkers in the low risk category are unlikely to experience any long term health risks from their consumption but may appreciate information on calculation of units and details of health risks associated with alcohol. (The Health Education Authority leaflets 'Sensible Drinking' and 'That's the Limit' may be useful). Those at the lower end of moderate would benefit from information on alcohol and details of sensible levels of consumption. It is not advisable for the weekly amount to be consumed in one or two sessions a week. Binge drinking should be strongly discouraged and the patient/client be advised to spread his/her drinking out over the week. For women drinking 21 units or more and men drinking 35 units or more the 'Cut Down on Drinking' leaflet is a useful tool in assisting patients in reducing their alcohol consumption. The aim of assisting a patient who is at moderate or high risk is to reduce their alcohol consumption and reduce the harm that alcohol is causing. Prochaska and DiClementi[20] believe that when people make changes they pass through various stages of change: (i) pre-contemplation; (ii) contemplation; (iii) action; (iv) maintenance.

Pre-contemplation

Here a person has not thought about harmful drinking. He/she needs information about alcohol and the relationship between consumption and harm or may know of the harm but choose not to make a change.

Contemplation

Here a person has the information about alcohol and has thought about his/her drinking but has not done anything about it. He/she needs further facts on harm, costs, etc. It may be valuable for the GP or nurse to indicate where he/she stands on the histogram (Figure 3). The person needs support to weigh up the pros and cons.

Action

A person is trying to reduce his/her consumption and may need support.

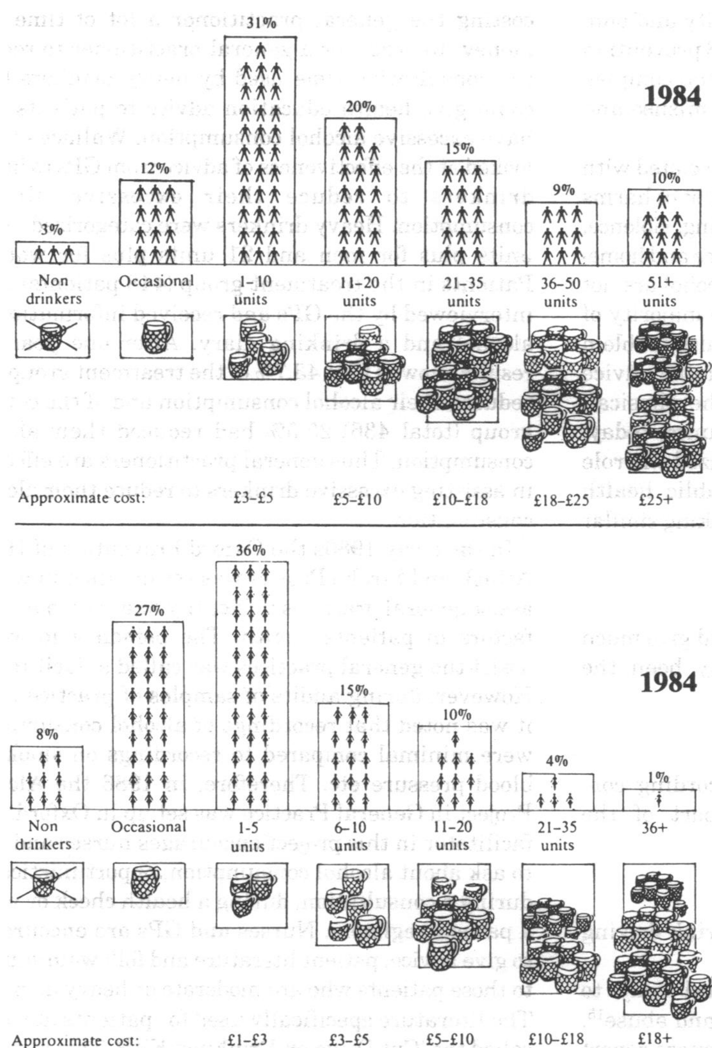

Figure 3. Distribution of units of alcohol consumed weekly by men (top) and women (bottom) in England and Wales (reprinted from the Alcohol Fact Sheet 14[21])

Many people seen by members of the primary health care team and in the hospital setting are in the pre-contemplation stage and require further information to make an informed decision about their own consumption and risk of harm. It is not possible to move a person from pre-contemplation to action. For a higher risk patient the aim is to assist him/her to move through the stages. A drinks diary is a valuable tool both for the heavy drinker and professional. The person has responsibility for self-monitoring and when completing the first weekly diary is often surprised by how much he/she consumes. The professional and the heavy drinker can together set realistic goals towards reducing consumption. It may be helpful to get a person to complete a diary not only on how much they drink but also when, where and with whom - this information may make a change easier. It is recommended that follow-up appointments are offered during which the diary can be referred to and progress discussed. If a pattern appears when alcohol consumption is heaviest, then these situations can be discussed, the person helped to avoid these and alternatives suggested.

Maintenance

Even when a person has reached a sensible level of consumption he/she will need the offer of continued support and follow-up or further information if difficulties arise. An appointment for a 6-month review of the drinks diary may be valuable. Many people will experience a relapse and need to be advised that this could occur. They need to feel that they have access to the nurse or doctor without embarrassment.

Many people who are reducing alcohol consumption will need the support of their family or friends. There may be other problem drinkers within a family whose support will be required and in turn their consumption reduced. Sometimes the partner has covered up the problem drinker's behaviour for example making excuses for the lack of money or absenteeism at work. They may need the opportunity to discuss their collusion and to be supported whilst the drinker cuts down. In the short term this may lead to family disruption. For example it may be easier to allow the husband to continue drinking than to withdraw alcohol. In this situation the family will require support from all those involved with the person who is reducing alcohol consumption.

The majority of heavy drinkers and people with alcohol problems can be supported by members of the primary health care team[17]. However, those people with severe problems or who lack a supportive environment may need referral to a specialist agency, for example, community alcohol teams and local councils on alcohol. Although alcohol is calculated in units of alcohol per week and levels of risk are discussed using these measures, the public are not generally familiar with the calculation of units. The Health Education Authority 'Beliefs about Alcohol' survey[22], for which 3387 adults aged 16 plus were interviewed, found that almost half the sample had never heard of the term 'unit' and that in general units of alcohol were not widely understood. People frequently underestimated the strength of beer and only a quarter realized that a glass of wine equals a single measure of spirits. Therefore, the first stage of an education programme in the community is to give people information on how to calculate units of alcohol. Members of the primary health care team are in an ideal position to do this and should recognize that with the extent of ill-health caused by alcohol they should ask the patient about alcohol as routinely as they ask about cigarette smoking and diet.

Conclusion

A patient or family with alcohol-related problems may take up a lot of a GPs time. It is therefore beneficial to identify these patients and their families not only for the health of the patient but to try to reduce consultation time. The GP can assist patients to reduce alcohol consumption but with the constraints of a busy surgery will need to involve the other members of the primary health care team in screening and advising patients. All the members of the team may feel they need further education and training with regard to alcohol and minimal intervention, and information on local agencies to whom a referral can be made. There also needs to be sufficient support for the GPs and the community/practice nurses from the community psychiatric nurses and alcohol treatment units who can be used as a source of reference or an agency to take a patient referral.

There are now over 100 facilitators employed by District Health Authorities or Family Practitioner Committees covering a population of 23.1 million. A facilitator is in the ideal position to assist and encourage general practitioners and practice nurses to ask about and record alcohol consumption. She/he can ensure that the professional has sufficient knowledge on the health risks of alcohol, feels confident in discussing these with patients and assisting and supporting them to reduce their drinking.

Finally, we as health professionals have a responsibility to inform patients about alcohol and its associated risks so that they can make an informed decision about one of the country's largest public health problems.

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