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PRACTICE OBSERVED

Practice Research

Managing alcohol problems in general practice

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Abstract

A questionnaire on the management of alcohol problems was sent to 467 general practitioners. Of the 312 who replied, nine tenths thought that they had a legitimate role in working with patients with drinking problems, but less than a half thought that they were adequately equipped to perform this role. Only two fifths felt motivated to work with drinkers, less than a third were satisfied with the way in which they worked with drinkers, and fewer than one in 10 obtained work satisfaction from working with drinkers. Only 29% of doctors regularly gave advice to patients to reduce alcohol consumption, but 56% believed that their advice was effective. Doctors who had positive attitudes to working with heavy drinkers undertook more work related to alcohol problems in their practice. There is a need to provide further education for general practitioners about alcohol related matters, and this education should include advice on intervention with heavy drinkers.

Introduction

The Department of Health and Social Security's Advisory Committee on Alcoholism emphasised the importance of general practitioners in both preventing and treating alcohol problems.[1][2] General practitioners have special opportunities for helping patients with alcohol problems because they are ideally placed to recognise the problem early and intervene.[3] Little is known, however, about general practitioners' attitudes to managing alcohol problems and what they currently do. This study was conducted to fill that gap.

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Method

The sample was the 467 general practitioners who had a practice address in Oxfordshire and west Berkshire. They were sent a postal questionnaire with a freepost return envelope during spring 1984. The questionnaire covered four main areas: background information about the doctors, the alcohol consumption of the doctors, the attitudes of the doctors to working with drinkers, and the beliefs about their own activities in working with drinkers.

The amount of alcohol consumption was obtained by using a quantity frequency question.[4] The respondents were asked how many days a week over the previous month, on average, they had had a drink of beer, wine, or spirits, and when they had a drink during the previous month, on average, how much of the above types of drink had they consumed. The respondents were divided into light, moderate, or heavy drinkers, according to the consumption of standard units of alcohol per week (where one unit is equivalent to half a pint of beer, a single of spirits, or a glass of wine or sherry): *women*—light = less than seven units, moderate = 7-27 units, heavy = more than 27 units; *men*—light = less than 14 units, moderate = 14-34 units, heavy = more than 34 units.

Attitudes to working with drinkers were obtained by giving the doctors 27 statements. The doctors were asked to indicate agreement or disagreement with the statements on a seven point scale. The statements were taken from the fourth version of the alcohol and alcohol problems perception questionnaire, which was developed from the Maudsley Alcohol Pilot Project.[5] The 27 statements are collapsed into two scales of role security and therapeutic commitment. Role security measures legitimacy and adequacy in working with drinkers; therapeutic commitment measures motivation, work satisfaction, and self esteem when working with drinkers. Both scales are highly correlated and may be combined into an overall attitude score, where a high score measures a more positive attitude to working with drinkers. Respondents were divided into one of three groups as measured by this score: low scorers = lowest sixth of the range, medium scorers = middle two thirds of the range, and high scorers = highest sixth of the range.

Results

Of 467 general practitioners, 312 (67%) replied. The respondents were similar in distribution by sex, age, and number of partners to the non-respondents. Except for alcohol consumption, there were no differences in

the response between men and women. Sixty six per cent of the general practitioners had received fewer than four hours of postgraduate education about alcohol related matters.

The distribution of alcohol consumption of the doctors was as follows: *women* (64)—light 69%, moderate 26%, heavy 5%; *men* (243)—light 68%, moderate 19%, heavy 13%. Alcohol consumption was not related to age or number of partners. Table I summarises the attitudes of the doctors to working with drinkers. There was no relation between overall attitude score and the doctor's alcohol consumption, age, or number of partners, but there was a strong relation between that score and the number of hours of postgraduate education about alcohol related matters that the doctor had received. Nine per cent of those who had received fewer than four hours scored highly on the overall attitude score compared with 14% who had had four to 10 hours of education and 38% who had had more than 11 hours (χ^2 for trend = 6·1, $p<0·05$).

TABLE I—*Attitudes of general practitioners to working with drinkers*

Attitude	Agree %	Neither agree nor disagree %	Disagree %
I feel I have a legitimate role to work with drinkers	93	6	1
I feel capable of working with drinkers	44	44	13
I am motivated to work with drinkers	39	42	19
I am satisfied with the way I work with drinkers	29	51	20
I get work satisfaction from working with drinkers	9	57	34

Table II gives the distribution of the frequency with which the doctors performed several activities related to alcohol, and table III gives the distribution of the proportion of patients who consulted with certain reasons with whom the doctor discussed alcohol. For all of the activities in these two tables there was no relation with the doctor's own alcohol consumption, but high scorers on the overall attitude score performed more tasks than low scorers. For example, 60% of high scorers initiated discussion about alcohol at least once a week, compared with 30% of low scorers (SND = 2·80, $p<0·01$), and 83% of high scorers discussed alcohol with more than three quarters of patients who consulted with gastritis compared with 59% of low scorers (SND = 2·47, $p<0·05$). Table IV gives the opinion of effectiveness in helping individual patients to reduce alcohol consumption: 88% of the high scorers on the overall attitude score believed that the general practitioner was effective in helping patients to reduce their alcohol consumption compared with 43% of low scorers (SND = 4·36, $p<0·001$).

TABLE II—*Distribution of frequency of activities for alcohol related advice (312 general practitioners)*

	Initiate discussion about alcohol %	Give advice to reduce consumption %	Use health education literature %	Refer patient outside practice %
More than once a week	49	29	2	2
Once or twice a month	31	45	5	6
Less than once a month	20	26	93	92

TABLE III—*Distribution of proportion of patients consulting with certain reasons with whom doctor discussed alcohol (312 general practitioners)*

	Patients with emotional disorders %	Pregnant women %	Patients with gastritis %
More than three quarters	26	49	70
One quarter to three quarters	36	22	22
Less than one quarter	38	29	8

TABLE IV—*Opinion of effectiveness of different agencies in helping individual patients to reduce alcohol consumption*

	General practitioner (n=312) %	Psychiatrist (n=312) %	Alcoholics Anonymous (n=312) %
Effective	56	54	83
Not effective	8	7	2
Undecided/don't know	36	38	15

Discussion

Sixty seven per cent (312) of the practitioners responded to the questionnaire, which indicates a high level of interest in the problems of alcohol. (The questionnaire took about 15 minutes to complete.) The non-respondents did not differ from the respondents in terms of sex, age, and number of partners, suggesting that on these variables there was no bias among the respondents.

Thirteen per cent of the men doctors were consuming 35 or more units of alcohol a week and 5% of the women were consuming 27 or more units. These levels are likely to be an underestimate of consumption. They are, however, closely similar to levels of consumption in a sample of professional men and women taken from a general population study in England and Wales.[7] Nevertheless, a large proportion of the doctors are consuming alcohol at levels that are generally regarded as unsafe and certainly at much higher levels than general practitioners believe to be safe.[8][8a]

It has been said that general practitioners have negative attitudes to working with problem drinkers and to be unaware of many of the heavy drinkers on their lists.[9][10] In this study, although most of the respondents believed that they had a legitimate role in dealing with problem drinkers and felt adequately equipped to perform this role, a minority felt motivated to work with drinkers, were satisfied with the way in which they worked with drinkers, and fewer than one in 10 received work satisfaction from working with drinkers. These attitudes are similar to those found in other studies of general practitioners in Britain and abroad (P Tether. Identifying and responding to problem drinkers in general practice. Paper presented to Royal College of General Practitioners' Conference on Alcohol Problems—Caring and Coping, 1984. D Robinson and M Morrissey. The management of alcohol related problems in general practice. Paper presented at WHO scientific working group of management of alcohol related problems in general practice, 1984).[11] They compare favourably with those of a group of professionals who attend summer schools on alcoholism at the Alcohol Education Centre and through whom the alcohol problems questionnaire was developed.[12]

The importance of general practitioners' advice to help patients stop smoking, based on opportunistic screening, has been clearly demonstrated.[13] Similar opportunities exist for alcohol, and there has in recent years been an increase in the use of minimal interventions[14] and bibliotherapy[15] in helping people with alcohol problems. General practitioners, however, seem to be lagging behind. Only a minority are giving advice often to reduce consumption and health education literature is hardly ever used, despite being widely available.[16] Despite not discussing alcohol as often as they might, most practitioners believed that their advice to patients to reduce consumption was effective.

Registers of patients at risk have been produced in general practice to alert doctors to the possibility of alcohol problems, yet at many relevant consultations alcohol is not discussed.[17] It is of concern that less than a half of general practitioners routinely discuss alcohol with pregnant women, despite there being firm advice that pregnant women should not drink at all.[18]

There seems to be three main conclusions from this study. Firstly, the practitioners might set an example by consuming less alcohol. There is an adage that says an alcoholic is someone who drinks more than his doctor. It is likely that the reduction of cigarette smoking by doctors has contributed to the overall reduction of smoking in society. Secondly, there is a need to give doctors more education about matters related to alcohol. In this study the practitioners who scored highly on the attitude score were more concerned in dealing with alcohol problems among their patients and had a greater belief in their effectiveness. The attitude score in turn was higher among those who had received more education. Thirdly, the education should concentrate on changing attitudes and providing a model of simple intervention for practitioners to use.

We need to shift our thinking away from "alcoholics" (a term that should be dropped) towards regarding alcohol as a risk factor. A simple model of intervention, similar to the Give Up Smoking kit needs to be developed, tested, and marketed.

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Safe limits of drinking: general practitioners' views

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Abstract

A survey was carried out by questionnaire of general practitioners' views on what the safe upper limits of alcohol consumption are for health education for men and women. The results showed lower limits than those suggested by "alcohol experts" in a previous survey.

Introduction

Primary health care workers have been urged to take the initiative in promoting healthy lifestyles, and there is evidence that advice from general practitioners can be effective in helping patients to stop smoking.[1] There is agreement about appropriate guidelines for health education for smokers because of the considerable evidence that even low levels of cigarette smoking can be harmful, but in the case of alcohol such guidelines are more difficult to define. There is abundant evidence that heavy drinking can be harmful but several studies have also indicated that when taken in small quantities alcohol may actually have a protective effect on health.[3]

There have been several attempts to define a safe upper limit of alcohol consumption. One of the first was made by Anstie, who in 1870 suggested a limit of 1·5 oz of pure alcohol daily (about 24·5 units a week[4]; 1 unit is equivalent to 8-10 g ethanol, contained in half a pint of beer, one glass of wine, or a standard measure of spirits).

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The results of a survey that we recently carried out showed that there was a considerable lack of consensus on the question of safe limits of alcohol consumption among a sample of "alcohol experts."[5] The present study was designed to ascertain what levels of consumption general practitioners consider to be appropriate for giving advice to their patients.

Methods and results

A random sample of 200 general practitioners was selected from a sampling frame of all who were registered with the family practitioner committees of the United Kingdom. The self administered questionnaire, which was mailed to the sample population, asked the following questions: (*a*) In your opinion, for a healthy man what would constitute a reasonable guideline in health education for a safe upper limit of drinking? (*b*) In your opinion, for a healthy woman, who is not pregnant or trying to become pregnant, what would constitute a reasonable guideline in health education for a safe upper limit of drinking?

Two of the general practitioners were no longer resident at their registered address. Of the remainder, 147 (75%) returned a questionnaire. All but three volunteered an opinion on safe upper limits of drinking for both men and women (table). The distribution of the advised levels did not differ

Number of units of alcohol a week recommended as upper limits of "safe" drinking (figures are numbers of respondents)

	No of units of alcohol/week									
	0-6	7-13	14-20	21-27	28-34	35-41	42-48	49-55	56-62	63-69
Men	22	36	39	13	19	6	3	3	3	
Women	30	47	46	9	9	2	1			

appreciably between those who worked in the north of the United Kingdom and those who worked in the south, nor was there any significant variation with age of the respondents. The mean (SE) advised safe upper limit of consumption was 17·9 (1·0) units/week for men, and 13·4 (2·4) units/week for women. These levels were significantly lower than the 30·9 (2·4) units/week for men and 19·4 (1·6) units/week for women advised by the "alcohol experts" in the previous study (t difference between means for men = 5·9, $p<0·001$; t difference between means for women = 3·9, $p<0·001$).

Discussion

The high response rate supports the findings of a previous study that suggested that there is considerable interest among general practitioners to provide health education about drinking. (P Tether. Identifying and responding to problem drinkers in general practice. Paper given at conference on "Alcohol Problems: Caring and Coping." Royal College of General Practitioners, London. October 1984.) The consistently lower levels advised for women indicate a general awareness of the evidence regarding the increased susceptibility of women to the harmful effects of alcohol. Most of the respondents suggested limits well below the 56 units a week recommended by the working party of the Royal College of Psychiatrists,[6] and the mean suggested limits for both men and women were appreciably lower than those advised by the "experts" in our previous survey. Remarkably, the mean suggested level for men approximates quite closely to Anstie's limit of 24·5 units a week.

The views of the respondents may not be entirely representative of general practitioners as a whole because of the possibility that the non-responders include a disproportionate number of practitioners who believe that the question of safe limits is irrelevant, regard health education as unimportant, or are heavy drinkers themselves. None the less, it appears that general practitioners believe that advice about the potentially harmful effects of alcohol consumption at levels below the safe limits suggested by the "experts" and considerably below the level recommended by the Royal College of Psychiatrists is appropriate for health education. These differences may reflect the recent publicity about alcohol and health, including campaigns such as that by the Health Education Council, which recommended weekly consumption below 21 units for men and below 14 units for women.

Though the overall level of agreement between the general practitioners and the "experts" is encouraging, the substantial variation in the limits suggested by individuals in both groups confirms the need to establish agreed, valid estimates of safe upper limits of alcohol consumption for men and women for health education. Furthermore, properly designed trials should now be carried out to evaluate the effectiveness of advice on drinking in helping primary care patients to use alcohol more safely.

We thank Dr V Nathanson and the other staff in the Professional and Scientific Division of the BMA for their help in selecting the random sample of general practitioners and in mailing the questionnaires, and the general practitioners themselves for providing us with their opinions.

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Correction

Standards for computer issued prescriptions

In this paper by the GMSC/RCGP Joint Computing Policy Group (27 April, p 1252) in paragraph 7(*a*) the following sentence should read: "Similar quantities of less than 1 mg should be written in micrograms—for example, 100 micrograms, not 0·1 mg."

Audit Report

Cervical cytology in a Guildford practice

We analysed retrospectively all the cervical cytology reports received in 1983 in a practice of four partners and a trainee general practitioner, caring for 8800 people. All the details from the reports were entered into the practice BBC microcomputer.

A total of 636 smears were taken that year but 42 patients (7%) had already moved from the practice by April 1984 when this study started. Another 24 reports (4%) could not be traced, 19 due to notes being untraceable and five because no report could be found in the notes. The 570 remaining reports had been taken from five sources: 416 (73%) from the practice, 87 (15%) from the family practitioner committee, 41 (7%) from the well woman clinics run by the district health authority, 23 (4%) from hospital clinics, and three (0·5%) from occupational health clinics. In our practice the female partner took the most smears (175).

We thought originally that most of the smears had been taken on women under the age of 30. Because the age-sex profile had been computerised, however, we could look at the figures in relation to the total number of women who were registered with the practice in each age group. This showed that a fourth of the women aged 20 to 24 and 35 to 39, over a fifth of those 25 to 29 and 30 to 34, and roughly a sixth of those 40 to 54 had had a smear in 1983. The results of the survey showed the weakness in our screening in women over 55, as only 7% of those aged 55 to 59 and less than 3% of those aged 60 to 69 had had a smear. All the "positive" smears were on women under 38. Twelve had cervical intraepithelial neoplasia 1 changes, five had 2 changes, and three had 3 changes; 547 (96%) of the smears were negative.—David Elliott and Hazel Yeo, general practitioners, 56 Epsom Road, Guildford, Surrey GU1 3LG. *(Accepted 6 June 1985)*