The general practitioner and the care of the abnormal drinker*

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" Whose is the misery? Whose the remorse?
Whose are the quarrels and the anxiety?
Who gets the bruises without knowing why?
Whose eyes are bloodshot?
Those who linger long over their wine,
Those who are always trying some new spiced liquor."

THIS quotation from the Book of Proverbs is one of at least 12 references in the Old Testament[1] that remind us that the problem drinker has been known to mankind for a few thousand years. Despite this awareness, the medical profession, and in particular the family doctor, is repeatedly being castigated for his lack of knowledge of, and interest in, the alcoholic in this country. Kessel and Walton[2] in 1967 stated that "many patients report that their general practitioners do not seem to have taken their alcoholism seriously". In 1970, the Office of Health Economics, in their publication, *Alcohol Abuse* pointed out that "many practitioners still do not recognize the disease or accept its medical content".[3] It is not surprising therefore, that the Medical Council on Alcoholism[4] and the National Council on Alcoholism[5] in their reports last year, both comment that few alcoholics present to their family doctor. The fault does not only lie with the doctor. Glatt[6] has written on the various reasons why the alcoholic does not readily come to the general practitioner for help—both the alcoholic and the family are often ashamed of the disease because of the social stigma attached to it, and they are frightened of the possible attitude of their general practitioner to their problem. What can we do to improve this situation? We must recognize the critical rôle of the *family doctor* in detecting the abnormal drinker in his practice, and in counselling the patient and his or her family. The finest contribution the general practitioner can make to the treatment of the alcoholic, is for him to *recognize* the abnormal drinker; if he is addicted, refer him for specialist care, if he is a problem drinker, then he requires counselling. We must also never forget the vital rôle of the family in the process of treatment and rehabilitation.

The first stage, therefore, is detection. With this disease, as Griffith Edwards[7] has suggested, the diagnostic acumen of the family doctor receives one of its greatest challenges. It has often been pointed out[6, 8-11] that the family doctor is in a good position to detect, at an early stage, at least some of those abnormal drinkers who consult him in the surgery. Even so, Moss and Beresford Davies found in their Cambridgeshire survey[12] that only 25 per cent of the alcoholics discovered in that county consulted their general practitioners because of their drinking problem, and only a further 15 per cent for conditions attributable to alcoholism. It has been suggested[7] that in the average general practice of 3,000 patients bearing in mind the possibility of considerable regional, urban–rural variations, there are about 30 abnormal drinkers, of which the general practitioner has only recognized three. How can we find and help

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the missing 27? In Manchester, we are developing a screening instrument in the form of a questionnaire to improve our pick-up rate which as a by-product, will produce some idea, albeit an underestimate, of the possible prevalence. This is not the occasion, and I am not able yet, to present a detailed analysis of the results. I can, however, illustrate the way in which the research is progressing and its potentialities. Over the first five months of the year's survey, 322 questionnaires were given to patients in the health centre (total population 12,000) who were believed to be themselves possible abnormal drinkers, or a close relative of one. This was achieved by constructing an 'alcoholic at risk register' analogous to the 'paediatric at risk register'. The categories which characterized the patient as being at risk, and who received a questionnaire included the following: certain physical diseases, mental disorder, certain occupations, certain classes of marital status, work problems, family disharmony, families with children suffering from psychological or psychosomatic disturbance, accidents, criminal offences, and smelling of drink. Of the 322 patients questioned, 55 per cent admitted to drinking problems to a greater or lesser extent, compared to two per cent of a control group of patients believed to be "not at risk". There were 118 present abnormal drinkers and 58 past abnormal drinkers. There were a total of 47 possible alcohol addicts. We also inquired about their immediate families which produced a further 98 abnormal drinkers, 36 of which are health centre registered patients. If these results are translated to produce a profile of a practice population of 3,000 patients in a particular overcrowded, poor, urban area of Manchester, the preliminary figures after five months survey are as follows. There are 23 abnormal drinkers, 12 who admit to drinking too much, 13 who admit to being abnormal drinkers in the past, and three who admit to drinking heavily in the past. Of the total 51 patients with some degree of present or past drinking difficulty, 12 admit to symptoms of physical addiction. It is a matter of conjecture what proportion of the heavy drinkers, and the past abnormal drinkers, are disguising their present drinking status. In 13 cases, I have been able to cross-check information given by one individual with that of the spouse. Three wives who consider they have drinking problems have husbands who do not mention it, and three husbands who consider they have drinking problems have wives who do not admit it. In the remaining seven cases, there is agreement that a drinking problem exists, although the husband and wife differ in each one's estimate of its severity. The project is only at an early stage, and these interim results are mentioned only as an illustration of the hypothesis that it is possible for the general practitioner to detect at least some of the hidden iceberg of this disease, before the patient is forced to admit it.

Turning now from recognition to treatment proper of the disease, the most important point to be made is that, for the general practitioner, both the problem drinker *and* the alcohol addict is our concern. Although the former is not physically addicted and, therefore, does not interest the average psychiatrist, he has problems of a medical and social nature which are our responsibility to try and solve, often with the help of community agencies. The heavy drinker with gastritis, or a poor work record, a wife with depression who is threatening to leave him, or a child with bed-wetting must, of course, command the general practitioner's attention even if he lacks the symptoms of physical addiction. Our attitude towards the abnormal drinker must be one of showing the patient that we recognize he is suffering from a medical disease which requires medical help. This has to be emphasized as a significant minority of general practitioners do not appreciate the medical nature of alcoholism. Levy in South Africa[13] reported that 15 per cent of general practitioners in a survey did not consider alcoholism a disease, and Rathod[14] found that 22 per cent of a group of 138 general practitioners ascribe 'moral weakness' or 'weakness of willpower', as the most appropriate description of alcohol addiction. A further 21 per cent consider these terms as moderately appropriate. The general practitioner should further show by the questions he asks, and the way he asks them, that he understands the problems with which the abnormal drinker

is often faced. He must then persuade the patient to accept the diagnosis—and this may take a year or two—and then, persuade him that he must become teetotal. Without these two stages, treatment is impossible, and this is perhaps why many family doctors may experience frustration, anger and disgust with their alcoholic patient[15]. We can refer the addict for hospital care but, on his return he, as well as the problem drinker, will require our constant support and encouragement. We must, with the help of the health team, seek out the physical, psychological and social factors of the disease, endeavour to discover the possible causes of the alcohol dependence, and offer solutions. We must not forget the spouse and children who need to understand the nature of the disease and to adjust to their changing rôle on the rehabilitation of the alcoholic. Alcoholics Anonymous and Alateen can offer valuable aid to enable the family to realize the help they must give to the alcoholic in their midst. Gradually, we hope to see the return of our patient to a normal place in society. We must except initially, at least, to be rebuffed by many of our patients, and their families, who may exhibit fear, denial rage, and hostility to our offers of help[16-18]. If we can understand their motives, these attitudes should not prevent us from persevering in our concern.

In conclusion, it can be said that the family doctor has a vital function in all aspects of preventive care: primary, manipulation of possible hostile environmental factors to prevent the onset of alcoholism, secondary, the early recognition of symptoms and prompt treatment, and tertiary preventive care, aiding in rehabilitation of the alcoholic and restoration of his place in his family and society, and prevention of relapse. A general practitioner wrote last year with reference to alcoholism "Why it is even suggested that this should be the responsibility of the general practitioner is surrounded by a certain mystery".[19]

I hope that this paper goes some way to helping to solve this apparent mystery.

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