Usage of NHS resources

In the UK, the general practitioner filters patients before they are referred or admitted to hospital (except for emergencies and cases of drug addiction and sexually transmitted disease) and it has been suggested that this results in a lower usage of hospital services than in other Western countries and a lower proportion of the gross national product being spent on health services. Certainly about 95% of consultations with doctors in this country[13] are with NHS general practitioners and this accounts for about 7% of the total expenditure of the NHS.[14,15] However, there are wide variations in general practitioners' referral and admission rates to hospital even after allowing for differences in age, sex and social class structures in their practices.[16] General practitioners are responsible for initiating all pharmaceutical services costs (12% of NHS costs) and about 85% of hospital costs (themselves 61% of NHS costs).[15] It would appear therefore that general practitioners could have a significant influence on the consumption of more than 70% of NHS costs.

These factors are important when considering the current reduction in resources allocated to some inner city district health authorities and the move to transfer care from hospitals to the community. If general practice has a considerable influence on the usage of hospital resources[17] and is particularly under stress in inner cities, there could be increasing problems for primary and secondary care services in inner cities if the difficulties for general practitioners working in these areas are not overcome. There is therefore a need for an overall national quality control of general practice, to determine whether the increased stress imposed by social conditions, hospital closures and transfer of services to general practice without the resources to go with them is imposing too great a strain on primary care, possibly leading to expensive and inappropriate use of hospital services, particularly in inner cities.

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Alcohol — finding solutions

WHY are screening tests for alcohol problems not widely used in general practice when it is known that general practitioners are aware of only a small proportion of the problem drinkers among their patients? This question was posed in the *Journal* in 1983 in the editorial 'Alcohol — looking for problems'.[1] The suggested explanation was that general practitioners were sceptical about the effectiveness of treatment for problem drinkers and doubtful that early detection was in any way beneficial. Recent surveys have confirmed that general practitioners are gloomy about the prognosis for problem drinkers, and only a minority are motivated to work with such patients. Even general practitioners with a special interest in the management of alcohol misuse have stated that it is unrealistic to aim to treat the bulk of problem drinkers in primary care. Is such pessimism still justified?

The development of an effective screening instrument presupposes that a 'case' can be defined adequately. While most clinicians would agree on the features of severe alcohol addiction, there is less agreement about the definition of early harmful drinking. Some people drink significantly more alcohol than their peers and a small proportion of these heavy drinkers will become addicted to alcohol. However, people who are not habitual heavy drinkers can suffer harm from their drinking and this is particularly true of the social morbidity that may accompany acute intoxication, for example, drunk driving and violent behaviour. Often such individuals are called problem drinkers. A common definition of a problem drinker is someone who experiences social, psychiatric or physical problems because of his or her repeated drinking of alcohol. But there is no general agreement about this definition or what evidence is necessary to indicate that a problem is caused directly by drinking too much. Epidemiologists are dissatisfied with the concept of the problem drinker but many clinicians have argued that this approach is quite sufficient to define individuals who need help. In general practice, problem drinkers are much more common than alcoholics.

Most screening techniques have been developed and validated among alcoholics in hospital. Clinical findings — for example, spider naevi, tremor, traumatic scars — and short questionnaires about drinking habits have been found to be more powerful screening tools than laboratory tests. Such techniques, however, may not be as useful in general practice. Few of the common signs and symptoms of alcoholism are common in general practice.[2] However, the most promising of the screening question-

naires, the CAGE questionnaire, has been tested in general practice. It comprises only four questions: (1) Have you ever felt that you should Cut down your drinking? (2) Have you ever been Annoyed by criticism of your drinking? (3) Have you ever felt Guilty about your drinking? (4) Do you drink in the morning (Eye-opener)? This questionnaire has been shown to be effective in detecting alcoholics from clinical populations using a cut-off point of two or more affirmative replies. Using the CAGE questionnaire the prevalence of alcoholism in patients attending general practice surgeries has been reported to be close to[3] or above[4] estimates of prevalence based on the direct survey of the general population. About half of those who score positively on the CAGE questionnaire drink more than eight drinks each day (the upper limit of safe drinking suggested by the Royal College of Psychiatrists). Another screening questionnaire used successfully in hospital practice is the 24-item Michigan alcoholism screening test which has questions such as, 'Do you feel you are a normal drinker?' and 'Have you ever got into trouble at work because of drinking?' Using this questionnaire, a high prevalence rate of alcoholism has been reported in general practice,[5] but no attempt has been made to quantify alcohol intake or assess other evidence of alcohol-related disability in those patients with a high score. Direct questions about quantity and frequency of drinking both at interview[3] and by multiple choice questionnaire[6] have also been shown to identify heavy drinkers in general practice. These simple easy-to-use tests could increase the number of heavy and problem drinkers known to their general practitioners. However, people tend to under-report the amount of alcohol they drink and problem drinkers may deny the harm they suffer. Consequently, such tests alone detect only about half of the problem drinkers in the community.

A major justification of the use of screening tests would be that early detection and treatment improved outcome. Pilot studies in the community and in hospital have suggested that modest but reliable reductions in drinking and related problems can follow such interventions, especially for patients with less serious drinking problems.[7] As yet these early interventions have not been assessed in general practice but pilot studies are under way. It has been suggested that general practitioners should intervene and educate their patients about safe limits of drinking but there is no evidence of the usefulness of such intervention.[8] This may prove to be sensible advice, but it does not justify widespread screening to detect and treat heavy drinkers as only a small minority of heavy drinkers may agree to participate in treatment.[7] Moreover, there is a drawback in focussing on heavy drinkers as the 'at risk' population for screening because the majority of identified problem drinkers in this country claim to consume less than eight drinks a day.[9] Thus an intervention aimed at the heaviest drinkers may exclude up to two-thirds of those suffering from alcohol-related disability. This is the so-called 'preventive paradox'.

Many unrecognized heavy drinkers already attend their general practitioner suffering with serious alcohol-related disability. Thus a case-finding approach may be more appropriate.[10] Although these problem drinkers attend their general practitioner more often than average, few ask directly for help with their drinking. The diagnosis of problem drinking is usually made by the family and not by the doctor. The Royal College of General Practitioners' Working Party on Prevention stated: 'It is currently common for general practitioners to treat dyspepsia, depression and anxiety for months or years without recognizing the existence of a serious drinking problem.'[11]

However, it is unlikely that such presenting problems will be managed satisfactorily until the drinking problem is identified and tackled. A low threshold of suspicion and an awareness of the pattern of complaints presented to general practitioners by problem drinkers will help in the identification of the problem.[10] This pattern has been clearly described[2,10,12] and often can be detected from the general practice medical card. Personal experience suggests that this is easier when problem lists or problem-oriented medical records are used. Social morbidity far outweighs medical morbidity. Marital disharmony is the most common presenting problem associated with identified problem drinkers in general practice. Other associations include repeated absenteeism from work, aggressive behaviour, trouble with the police and debt. The only common physical complaint is an upset stomach with no obvious cause. Minor psychiatric complaints such as anxiety and depression are also prevalent. The only common feature of alcoholism is the smell on the breath of alcohol but occasionally a raised mean cellular volume on routine haematology arouses suspicion. Reports of regular attendances at accident and emergency departments may provide an indicator; indeed, evidence of repeated minor trauma may be visible. Such presenting problems should arouse suspicion of heavy drinking. Simple tactful questions about frequency and quantity of drinking may be sufficient to confirm the suspicion. If the patient is offhand or reluctant to discuss his or her drinking, the CAGE questionnaire could be available as an *aide-mémoire*. This case-finding approach among patients already presenting with social and medical problems known to be associated with heavy drinking is more easily jusitifed than widespread screening.

Counselling at an early stage may yet be shown to be beneficial for the majority of problem drinkers coming to the attention of their general practitioner. Treatment based on advice about safe limits of drinking and reduction of quantity and frequency of drinking, self-help manuals or diaries of drinking have been described.[8,13] Follow-up by laboratory tests, such as estimation of gamma-glutamyl transpeptidase levels, may be useful measures of progress. These laboratory results may be discussed with the patient as a tangible measure of bodily recovery. Referral to a specialist agency is appropriate for those who fail to respond to such simple methods, lack social support or have suffered significant alcohol dependence or serious physical harm. These strategies have been effective in other clinical settings and may be shown to be useful in general practice. Until such evidence is available, however, general practitioners will not be persuaded to undertake widespread screening. The attitude of many doctors has been summarized well:

> 'Compiling a register of problem drinkers is likely to prove only an embarrassment until intervention ... is seen to result in a worthwhile outcome for the sufferer and family.'[10]

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