Australian Alcohol Guidelines – A Practitioner Perspective

I have been unsure precisely how to tackle this presentation.

First up I thought about a dazzling review of the research data exploring how various groups of practising clinicians had successfully employed the Australian Alcohol Guidelines (AAGs) in their work? Or even a somewhat less dazzling review of all the studies that had carefully and methodically looked at the improved clinical outcomes attributed to the use of the AAGs in practice.

Unfortunately, I was unable to locate a significant body of work that was likely to prove fruitful in taking this approach to the subject.

I then decided to address the subject by exploring the role AAGs could have played through the various clinical roles I've had working in rural Victoria for the past 30+ years.

Thinking back to my earliest experiences in the hospital emergency department as an Intern where on many occasions I encountered a legendary middle-aged alcoholic male who frequented the casualty department, invariably intoxicated, invariably complaining of some medical problem -like nausea, vomiting, abdominal pain – or, after suffering some superficial injury as a result of a fall or accident. He stands out in my memory for 3 things – firstly, because he did a pretty mean Dean Martin impersonation of ***"Everybody loves somebody sometime",*** secondly because he has the distinction of being the first (&last) patient to catch me unawares and plant a sloppy kiss squarely on my cheek - as I attended to one of his lacerations. And thirdly I've reflected on how I could have done more to have prevented him ending up running his car into a tree in a single vehicle accident on a lonely country road some years later? If only I'd had the AAG in the 70's – perhaps things would have turned out differently for "Deano".

Perhaps during the next 11 years as I worked in a busy general practice……. incorporating the AAG may have assisted me in identifying some of the risky drinkers I'd come to treat in later years with their more problematic alcohol dependency problems?

In the 80s, shortly after commencing work in the 2 worker, community A&D agency, I remember being consulted by a well connected, well dressed, professional woman who'd travelled three hours for our first consultation. Fighting back a flood of tears she begged me to help her beat her longstanding alcohol problem – a glass of sherry every night. A problem she just couldn't lick, but found most distressing! How I wish I'd had the AA G to help me with that one!

A year or two later, I recall a 38 yr old ex jockey who was brought unconscious to our hospital's emergency department on Christmas day. He was not a diabetic but was quite hypoglycaemic (low blood sugar), weighed just over 30 kgm and smelt strongly of alcohol. He regained consciousness quite rapidly after his hypoglycaemia was corrected. Despite a long history of having a slab of beer delivered daily by taxi to the bungalow in which he spent both his waking and sleeping hours at the back of his parent's property, he neither developed symptoms of alcohol withdrawal nor required any treatment to prevent withdrawal during his 4 or 5 day hospital admission. Perhaps if I'd only had the presence of mind to talk to him about the AAG………..

I could go on…………..but I won't. My very much tongue-in-cheek attempt to link the AAG with those and many other real life clinical scenarios – is simply a vehicle

to try to make a couple of points that I finally decided was the way I'd tackle this presentation.

1. The most obvious comment to make is that from a clinician's perspective I don't see substantial inherent problems with the 12 guidelines or the 'summary of the guidelines for low risk drinking', but it seems to me that there are potential dangers in how, when and why the guidelines may be applied in clinical practice. In this way, the guidelines are much like the drug alcohol itself – the real dangers are in inappropriate use of the guidelines.

Arguably, the Guidelines can appropriately be used in managing a range of situations in clinical practice – where encouragement, challenging entrenched patterns of consumption, reinforcing appropriate behaviours or educating clients, their families or carers may be perfectly relevant and appropriate. Some of the key determinants that might determine the appropriateness or otherwise of the use of the guidelines in ***a clinical setting*** might include:

- The degree of appreciation that the clinician has of the detail of and rationale behind each of the individual guidelines and their limitations, special riders etc.
- A detailed understanding of the patient or client, their health, the medications they are taking, their social and psychological health etc, etc.
- Clinical judgement in knowing how to bring these two considerations together to produce the desired, appropriate clinical response in the client or patient.

Policy makers for example, by contrast, may need a detailed understanding of their intended target group, rather than an understanding of the characteristics and circumstances of the individuals within that group. Experience in handling political masters may be a skill required in this context, which would be unlikely to be necessary in a clinical situation.

2. Secondly, clearly articulated riders, qualifications and background information, ***specific for <u>each</u> of the intended target groups***, would in my view be useful. The introduction to the ***Australian Alcohol Guidelines: Health Risks and Benefits*** includes this statement:
"In its current form, the document is intended primarily for professional groups, educators, and industry and policy makers". Furthermore, in the introduction to the ***Context and Evidence Base*** section of the document the list of target groups is extended to include: "...... planners, health professionals, community groups and those responsible for the provision of alcohol"..... It seems to me that these groups are diverse with equally diverse potential applications and uses, which I'd argue suggests a need to review whether one document can realistically be expected to meet the needs of such a list of groups.

3. Finally, let me flag a further example of specific contextual information in the guidelines documentation, which can in my view create unintended difficulty, or confusion in a particular setting or context.

Again referring to the ***"Australian Alcohol Guidelines: Health Risks and Benefits",*** the section "***Alcohol and its effects: an overview"***; problems related to alcohol use have been characterised as being:

- ***Dependence*** – withdrawal symptoms, loss of control,
- ***Regular use*** – cirrhosis of the liver, cognitive impairment, pancreas damage, etc
- ***Intoxication*** – alcohol-related violence, risky behaviour, road trauma & falls.

Something of the relationship between these problem groups are represented by "Thorley's Balls". For social researchers, policy makers etc this is a perfectly

functional and useful way to categorise and depict ***groups of people with alcohol problems.***

In the context of general practice, my experience suggests a more appropriate way to categorise and depict alcohol-related problems is to consider three characteristics that define ***an individual's relationship with alcohol***. These three characteristics are:

- ***Consumption pattern*** – where the emphasis is on accurately grasping the individual's drinking pattern and length of drinking history rather than on accurate measures of frequency & quantity consumed. That's not to say some idea of Q&F isn't important, but for practical clinical decision-making in general practice, being able to precisely define Q&F is time-consuming and unnecessary (except when research is involved)
- ***Dependence*** – where dependence is specifically confined to the presence or absence of withdrawal symptoms on ceasing or substantially reducing alcohol intake.
- ***Addictive*** (cognition or behaviour) – where the key features are loss of control, denial, deception & deceit.

Note : can't represent this pictorially by modifying Thorley's Balls

: the categorisation is more accurate in allowing separation of 'dependence' from 'addiction'. NB Specialist addiction practice rarely, if ever sees clients who are not both dependent and addicted. This situation is not uncommon in GP

: it reduces the emphasis of Q&F appropriately for the GP setting

(eg the pattern of consumption for a 50 yr old male with is drinking 3 SD of alcohol daily& has diabetes and poorly controlled hypertension may well be appropriately treated by suggesting alcohol reduction even though he may be drinking within the recommended guidelines and may not be at particular risk of developing 'dependence' (by Thorley's definition) or short term or long term alcohol-related problems.

: it still fits within the DSMIV and ICD classification of diseases by operationalises these conditions in a way which is more relevant to the GP setting.

: it fits better the medical practice of taking a history of symptoms, examining for signs, and formulating a diagnosis with definable characteristics. This in turn allows GPs to assess the level of complexity of A&D problems in a way which assists GPs to make a decision about which patients (by alcohol-related characteristics) can the GP look after them selves and which ones should they refer on.

: better fits both the reality of the GP setting and the GP's primary role & interest (cf the interests of the A&D sector or government policy)