CLINICAL

Short review

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Alcohol-related illness in the hospital

WS Hislop
Consultant Physician, Department of Medicine, Royal Alexandra Hospital, Paisley, UK

ABSTRACT Alcohol-related illness is a major problem in Scotland. Currently, its treatment in hospital is under-resourced, and patients are scattered around different departments. This review examines how Scotland's health service can be adapted and redesigned to improve care for patients with alcohol-related illnesses and minimise the disruption they cause in hospitals.

KEYWORDS Alcohol, liaison psychiatry, redesign, resources, Scotland

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***Correspondence to* WS Hislop, Department of Medicine, Royal Alexandra Hospital, Corsebar Road, Paisley PA2 9PN, UK**

***tel.* +44 (0)141 314 6861**
***e-mail* Stuart.Hislop@rah.scot.nhs.uk**

On 7 August 2008, the BBC reported that in 2007 there were a total of 455 drug-related deaths in Scotland. While each of these deaths is tragic for the families concerned, the announcement illustrates clearly how much politicians and the media ignore the 'elephant in the room'. In 2007 there were 1,800 deaths from alcoholic cirrhosis alone, not counting mortality from alcohol-related violence, road fatalities attributable to drunk drivers or inebriated victims, and suicides while intoxicated – a total estimated to be around one in 30 of all deaths in Scotland.[1]

Scottish politicians seem to be unable to choose between continuing the liberal regime proposed by Christopher Clayson in 1973,[2] which formed the basis of the 1976 Licensing Act, and a more restrictive approach. The recent debate in the Scottish Parliament over raising the age at which liquor can be purchased at off-sales premises is a typical example.[3]

Essentially, the argument for a more restrictive approach is that reform and free choice in the area of alcohol supply have brought us to the current state of affairs and that measures that limit alcohol supply via taxation, outlet availability and hours of sale (all shown repeatedly to work in other countries) ought at least to be tried.[4]

Those who work in almost any National Health Service (NHS) hospital specialty will be aware of the effect of alcohol-related problems on everyday workload. The burden is perhaps borne most by certain key departments such as emergency medicine, gastroenterology, maxillo-facial surgery and orthopaedics. The impact is also felt in staffing high-intensity shifts. Working in the emergency department of any big city hospital between Friday night and Monday morning is not a job for the faint-hearted, and staff are increasingly reluctant to work these hours.[5] As well as dealing with the particular medical problem that has brought the patient to hospital, staff endure the added complications of having to handle drunken individuals and those suffering from alcohol withdrawal. There is often verbal or physical abuse from patients themselves (or their friends and relatives) towards staff and even other patients. There is an ever-present danger of assault, and it is difficult to find support agencies out of hours.

We have become almost immune to the shocking statistics that overindulgence in alcohol has brought to Scotland's health services. Rather than revisiting these in detail – they are well set out and summarised in the Government's recent discussion document *Changing Scotland's relationship with alcohol*[6] – it would perhaps be opportune to see if we can improve the way we tackle alcohol problems in Scottish hospitals, and whether it is time to think about moving away from traditional models of care.

WHERE SHOULD PATIENTS BE MANAGED?

In previous years the 'short stay ward' was the solution that many hospitals employed to cope with such problems. Patients with minor injuries who were drunk were often admitted there overnight and sent home in the morning. Others with self-poisoning or minor orthopaedic injuries, awaiting hand surgery for example, were similarly accommodated. Most of these patients were only in hospital for up to 48 hours. These wards were generally run as an adjunct to the old-fashioned 'casualty' department. Patients were usually seen by the most junior members of the medical and surgical teams. As a result, there were often 'near misses'; e.g. overlooked extradural haematomas, undertreated delirium tremens resulting in convulsions, injury or aspiration, etc. The Platt report[7] of 1962 recommended that 'casualty' should be run by specially trained consultants, the forerunners of today's emergency medicine specialists.

The other problem with short-stay wards was that they were never properly resourced in most hospitals, and many were subsequently closed with the integration of their functions to other specialist units. Thus head injuries were looked after in surgical beds, overdoses in medical wards and alcoholic patients where their care

seemed most appropriate. Unfortunately, this meant that they were often scattered around the hospital, causing mayhem in many different areas.

In the 1970s and 80s many district hospitals were designed with inpatient psychiatric beds. This was in theory an excellent idea as many psychiatric patients come into hospital with medical problems and many clinical problems in a general hospital have strong psychiatric overtones. The idea was that these units would be areas where both psychiatrists and general clinicians could come together to manage their patients jointly. The problem was that at the time these units were established, psychiatric services were not organised with sufficient subspecialists in liaison psychiatry to make this practical. Even now, despite expert recommendations, it appears to be very much a 'Cinderella' specialty, with only one or two major Scottish teaching hospitals having liaison psychiatry services that work effectively and are properly resourced.[8]

One of the problems with alcohol-related illness is that many of the patients have complicated clinical, psychiatric and social needs. Modern management fixation with throughput and fast turnover of beds means that these patients' needs are often not met adequately. Take the example of alcoholic liver disease. In many hospitals these patients were managed in whatever medical ward had space. Such a patient could have an injury, end up being treated for a fracture in an orthopaedic ward and going into decompensated liver failure. Similarly, a patient with ascites might end up in a cardiology or a chest ward because the gastroenterologists in that particular unit had decided that they were not going to take sole responsibility for all alcohol problems. The result was that their liver disease was less expertly managed.

In those hospitals where alcoholic liver disease is looked after as part of gastroenterology,[9] a certain expertise is often built up on the part of the nursing staff in caring for these patients, who tend to be managed along with patients suffering from liver disease of other types. A consequence of this policy is that the nurses in these units become very skilled at looking after alcohol problems per se, and therefore there is a drift of other alcohol-related medical problems such as Korsakoff's psychosis, delirium tremens and withdrawal symptoms to that department.

In our hospital, serving a population of approximately 250,000, at any one time in a 30-bedded gastroenterology ward we have about 20 patients suffering from the effects of alcohol in one form or another, although the majority of these will have alcoholic liver disease. Bearing in mind that there are significant alcohol problems in other departments in the hospital, it would be logical to assume that an alcohol ward in the average district general hospital would be permanently full were it designated for that use.[10,11]

There is a precedent that in times of crisis, special units have often been set up in the Scottish health service to meet a particular demand. Chest hospitals grew up in the 1920s and 30s to meet the demand of tuberculosis treatment and performed an excellent function well into the 1960s. They became the forerunners of today's excellent respiratory medicine units, changing their role from dealing with the ravages of tuberculosis to damage caused by smoking. The statistics would suggest that we may have at least reached a steady state in the battle against tobacco-related respiratory illness. Not so with alcohol, however. The death rates from cirrhosis, alcohol-related injuries and crime go steadily upwards.[12]

SUGGESTED MEASURES

The Government and politicians endlessly debate new initiatives and new plans to deal with the problems, but there is very little sign of the effective action that is required. Unfortunately, this action would mean annoying vested interests such as the drinks industry or upsetting the voters by increasing the cost of alcohol or making it less available.

Make no mistake – the only effective measures to counter an alcohol epidemic such as Scotland's current one is to make drink more expensive, reduce the number of outlets that sell it and restrict the hours within which it is purveyed.[4] Education and culture change all take far too long, and the health service needs to do something now to cope with the current levels of alcohol-related illness which are likely to continue until our politicians finally realise that this problem requires serious action. The health service requires to be funded adequately to deal with it, and it looks as though hypothecated taxation could be the logical way forward. These powers are reserved to Westminster, so the only thing the Scottish Government can do is legislate on the Licensing Act, which unfortunately it made potentially even more liberal in 2005.

It would seem therefore that the health service may have to look out for itself in relation to this problem, and redesign services accordingly. I suggest the following measures would at least be a start:

- Make teaching on alcohol-related illness a much more prominent part of the medical undergraduate curriculum.
- Fund hospital alcohol and drug services in proportion to the actual number of cases being dealt with. There has historically been a wide discrepancy in funding with alcohol-related projects, until recently, receiving only a fraction of the drugs spend, despite being a vastly more prevalent problem.
- Teach management of alcohol-related illness to key groups such as trainees in gastroenterology, acute medicine and psychiatry.

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- Reintroduce the concept of the visiting consultant psychiatrist, preferably one trained in liaison work or in drug and alcohol problems. A daily visit by such an individual to the district general hospital or, if the hospital was large enough, actually based there with access to psychiatric beds, would be a major step forward. Such consultants could help run alcohol liaison services, which are increasingly vital in bridging the gap between acutely medically ill patients with an alcohol problem and their rehabilitation in the community.
- Ensure adequate resource for alcohol liaison services (see above).
- Hospitals should consider developing units where there is both medical and nursing expertise to deal with alcohol problems, where these patients can be looked after with minimal disruption to the working of the rest of the hospital. There may need to be trade-offs in some areas, such as gastroenterologists coming out of acute medicine, in order to undertake this additional specialist work.

CONCLUSION

In summary, Scotland's alcohol problem is not going to go away. Political, cultural and social measures will take at least a generation to work, and the health service is stuck with a severe and dangerous problem on its doorstep now. It is even likely that the numbers affected will increase in the next decade. Indeed, the death rate from alcoholic cirrhosis is currently about 1,800 per year and rising steadily. It may well approach that of lung cancer (4,115 per year) in the next 10 years.[11] The NHS therefore needs to develop measures to allow its smooth functioning, and yet at the same time care for the needs of patients with alcohol-related problems, until such time as effective political action comes to fruition.

KEY POINTS

- One of the problems with alcohol-related illness is that many of the patients have complicated clinical, psychiatric and social needs. Modern management fixation with throughput and fast turnover of beds means that these patients' needs are often not met adequately.
- As well as dealing with medical problems, hospital staff endure the added complications of having to handle drunken individuals and those suffering from alcohol withdrawal. There is often verbal or physical abuse from patients themselves (or their friends and relatives) towards staff and even other patients.
- In hospitals where alcoholic liver disease is looked after as part of gastroenterology, a certain expertise is often built up on the part of the nursing staff in caring for these patients.
- Political, cultural and social measures will take at least a generation to work. The health service may therefore have to look out for itself in relation to this problem, and redesign its services accordingly.
- Measures needed to tackle the problem in the health service include additional funding, changes in the medical curriculum and training, reintroducing the concept of the visiting consultant psychiatrist to district general hospitals and the development of specialist alcohol wards.

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