THE MANAGEMENT OF ALCOHOL-RELATED PROBLEMS IN GENERAL PRACTICE IN NORTH INDIA

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SUMMARY

Twenty-seven general medical practitioners (GPs) were administered WHO semi-structured schedule enquiring "The Management of Alcohol-Related Problems in General Practice". Majority of the GPs had some involvement in each one of the specified alcohol-related problems. The involvement in alcohol and health education had been modest. Involvement in the control and regulatory activities was minimal. None of them felt that they had any role in the development of health and alcohol policy. Treatment response to three typical situations appeared to be quite appropriate. To regulate production, to market less potent drinks at cheaper rates, to organize public health education programme through mass media were the suggestions made by them. It is suggested that GPs can and should be encouraged in leadership roles in policy decisions regarding the delivery of services, control and regulation of alcohol and research.

Introduction

The specialized treatment units presently available or likely to become available in the near future will not be adequate to cope with patients of alcohol-related problems and therefore a large proportion of such patients in the country will have to approach general practitioners and will have to be taken care of by them. In addition, the general practitioners have a large role to play in many legal/administrative aspects of control and treatment, such as policy and procedures for licensing for sale of alcoholic beverages, certification of patients brought by the police for alcohol-related problems and education of the para-professional health workers, teachers, police, judiciary as well as the general public in the nature of alcohol-related problems and their management.

The extent of alcohol-related problems in India is not reliably known. A few studies recently reported have addressed themselves to the pattern and extent of alcohol use in the country and of the various alcohol-related problems. Dube and Handa (1969) reported that 0.77 per cent of 29,468 in the general population habitually used alcohol. Deb and Jindal (1974) in a study of pattern of alcohol use in villages in Ludhiana district of Punjab found that 74.1 per cent of adult males used alcohol. Lal and Singh (1978) in a study of a village in Sangrur district of Punjab reported that 49.6 per cent of males, 15 years of age and older, were alcohol users.

Sethi and Trivedi (1979) in a survey in a rural area adjoining Lucknow found that 32.1 per cent of males above 10 years of age, and none of the females, indulged in alcohol with a frequency of at least once a month. In an earlier study by us (Varma et al. 1980) on a random sample of 1031 in the general population, urban and rural, 18 years of age and older by individual verbal administration of a structured questionnaire, we found that 23.7 per cent of the total sample and

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41.0 per cent of males were current users. 11.2 per cent of the total sample could be categorized as regular users (consuming one or more pegs per week).

In a study earlier reported by us (Wig and Varma, 1977), we found that of the patients seeking treatment at 13 selected psychiatric centres in India, alcohol abusers were higher in number than abusers of all other drugs combined. During 1974, 479 cases of alcohol dependence were treated at these 13 centres. It is obvious that alcohol-related problems represent a considerable public health problem in India.

The available specialized treatment resources in the country for alcohol-related problems are extremely meagre. In a study reported in 1977, Wig and Varma (1977) surveyed 13 psychiatric facilities in India, but did not find any specialized and exclusive unit for treatment of drug and alcohol dependence in the entire country.

The inpatient treatment of alcohol and drug dependence is carried out at the general psychiatric centres in the country. In other words, patients of alcohol and drug dependence are also admitted along with patients of other psychiatric disorders to these inpatient services, and treatment is administered as required. These facilities generally lack the specialized treatment requirements for alcohol and drug dependence; for example, restrictions on movements and access, intensive psychotherapies, etc. Prominent among such treatment facilities, as far as alcohol-related problems are concerned, are medical college hospitals at Lucknow, New Delhi (Maulana Azad), Madurai, Bombay, and Madras, the All-India Institute of Medical Sciences, New Delhi, the National Institute of Mental Health and Neurosciences, Bangalore, and the Postgraduate Institute of Medical Education and Research, Chandigarh (PGIMER).

As part of a WHO collaborative project, "Management of Alcohol-related Problems in General Practice" (MNH/DAT/84.7), a study was carried out in India. The present report summarises the experience of this exercise carried out in Chandigarh and its adjoining rural area in North India.

Material and Methods

It was planned to study five general medical practitioners in each of the following four categories:
A. Urban aged under 40
B. Urban aged 40 or over
C. Rural aged under 40
D. Rural aged 40 or over

However, it was felt that in India there may be considerable differences between doctors who are in the government service and those in the private practice. Many doctors in the government services in the country are not permitted private practice at all. In other words, they are in a full-time salaried position. On the other hand, many doctors are in purely full-time private practice, with no commitment to the Government system. It was considered advisable to study the two groups separately.

For the purpose of the present study, a general medical practitioner was defined as someone possessing a degree in modern, allopathic system (i.e., M.B., B.S.) presently actively involved in general practice. Those with only a licentiate or diploma qualifications, and those practising indigenous systems of medicine (i.e., Vaidas, Hakims, and Homoeopaths) were not selected. Similarly, specialists, i.e., those possessing a postgraduate degree (e.g., MD or MS) in any branch of medicine
were excluded, although those with a simple diploma (e.g. D.C.H., D.G.O.) were not excluded from selection.

A list of private practitioners available under various categories was prepared. The urban cohort was recruited from the city of Chandigarh. Of the rural cohort in government service, the younger practitioners were recruited from the primary health centres of Raipur Rani which is located approximately 40 km from Chandigarh and those older from other outlying areas.

The general practitioners thus selected were administered the WHO schedule* "The Management of Alcohol-related Problems in General Practice".

In each case, a prior appointment was taken with practitioner concerned. All the schedules were filled by the investigator on the basis of a live, individual, face-to-face interview with the practitioner. At the interview, only the practitioner was present along with the investigator and others like his colleagues and assistants (as also patients) were rigorously excluded from the interview situations.

The data were collected on a semi-structured schedule. The data collected included: a) personal information on the general practitioner interviewed; b) his role in treatment, education, control, policy development and research in relation to alcohol-related problems; c) his experience of other practitioners involved with problem drinkers; d) his own assessment of the extent of alcohol-related problems in the country; e) his responses to three hypothetical typical alcohol-related problems; and, f) his suggestions as to what three things could be done in the country now and within the next five years to improve the response of medical practitioners to help prevent alcohol-related problems.

Results

A total of 27 general practitioners were interviewed and the proforma individually completed. The following groups were represented amongst those interviewed:

Private practice, aged under 40, urban (PYU) = N-5
Private practice, aged 40 or over, urban (POU) = N-5
Private practice, aged under 40, rural (PYR) = N-2
Government service, aged under 40, urban (GYU) = N-5
Government service, aged under 40, rural (GYR) = N-5
Government service, aged 40 or over, rural (GOR) = N-5

The sample accordingly consisted of 12 practitioners from rural and 15 from urban areas; 17 younger and 10 older practitioners and 12 in full-time private practice and 15 in full-time salaried government service.

Although we had planned to study them, we could not find any practitioners for the study in the categories of "private practice, aged 40 or over, rural" and "government service, aged 40 or over, urban" and only two in PYR category. Most of the private practitioners in the rural areas were under-qualified, possessed only a diploma or licence qualification and did not possess the M.B.,B.S. degree as required by our selection criteria. Many others follow the indigenous system of

* MNH/DAT/84.11.1 available with Dr. Marcus Grant, Division of Mental Health, W.H.O. 1211 Geneva 27, Switzerland or from the authors.
medicine. These were not included in the present study. Accordingly, only two younger and none older private practitioners could be recruited from the rural areas. Another difficulty was in recruiting older general practitioners in the government service. In the government service, as they attain seniority, the doctors are either transferred to headquarters or are put in administrative positions and hence are no longer directly involved in general practice. Alternatively, many acquired postgraduate specialized qualifications and thus ceased to be general practitioners.

Table 1 gives the age and sex distribution of the groups.

| Group | N | Age (years) Mean | Range | Male | Female |
|-------|---|-----------------|-------|------|--------|
| PYU   | 5 | 31.6            | 29-35 | 5    | 0      |
| POU   | 5 | 64.2            | 49-72 | 5    | 0      |
| PYR   | 2 | 30.0            | 28-32 | 2    | 0      |
| GYU   | 5 | 36.4            | 35-37 | 2    | 3      |
| GYR   | 5 | 33.2            | 19-37 | 5    | 0      |
| GOR   | 5 | 54.2            | 48-58 | 3    | 2      |

The time taken for the interview varied from 25 to 50 minutes. It was the lowest in the younger, urban, private practitioners. Those in the rural setting and those older took longer. The cooperation received from each practitioner was excellent. Furthermore, the respondents appeared to be taking the interview seriously and at no point did it appear that they gave a casual or frivolous answer. Some, especially those from the (government-run) private health centres utilized this occasion to verbalize the difficulties and problems in their work and fulfilment of the several roles assigned to them. Some practitioners were curious to know as to gains, if any, that could come to them as a result of the present investigation.

The results relating to the different questions investigated are presented separately.

1. His involvement in providing help for people with specified (and other) alcohol-related problems: The question pertained to their actual involvement for people with alcohol-related problems with each one of the specified problems. The general practitioners were asked to quantify their involvement as often, sometimes, and never. In the analysis, the responses were given the weightage of 2 for "often", 1 for "sometimes" and 0 for "never", and the total score of the entire group for each role or involvement ascertained. In addition, the percentage of the total group with any involvement with a particular problem was calculated.

Out of the total group of the general practitioners interviewed, a large majority had had some involvement in each one of the specified alcohol-related problems. 85.2 per cent had been involved in providing help for people with family problems, followed by those with withdrawal, and intoxication (77.8 per cent each), domestic violence and road accidents (74.1 per cent each), dependence syndrome (70.4 per cent) and work and financial problems (66.7 per cent each) followed by other specified problems. In the same way, the following problems, in decreasing order, obtained the highest weighted scores for involvement: family problems, intoxication, road accidents, withdrawal, financial problems, domestic violence, dependence syndrome and psychological problems. The involvement was lowest in domestic accidents (22.2 per cent) and work accidents (48.1 per cent). Of the Non-specified problems, 51.9 per cent indicated involve-
ment with gastritis and 29.6 per cent cirrhosis or peripheral neuropathy.

Various groups were comparable in their experience of problems helped except that PYU had a clearly lower involvement. POU and GYU had been more involved with family problems and GYR with public violence. GOR had maximum experience with alcohol intoxication.

2. Their involvement in the education of the general public, politicians, policy makers and professional colleagues in general and alcohol education: The involvement of the respondents in alcohol education as well as health education had been modest. Only 40.7 per cent had any involvement in general education, and only 14.8 per cent in alcohol education of the general public. The involvement in education of general public was greater in case of GYR and GOR groups. Very few had been involved in the education of the professional colleagues. This mostly consisted of the education of the younger colleagues at the meetings of the Indian Medical Association. All respondents from the GYR group had been more or less involved in the general education of “other health professionals”.

None of the respondents felt that he or she had been involved in the education of politicians or policy makers or of “practitioners in non-health sectors”.

All those involved in education had been primarily involved in the general education and not in alcohol education as such.

3. Their involvement in the management of health and alcohol services, locally and nationally: The involvement of the respondents in the management of services had been modest. 37 per cent, mostly from the GYR group had been variously involved in the management of general health services at local level. Practically none had been involved in the management of alcohol services locally and none at the national level of general health or alcohol services.

4. Their involvement in the control and regulation of alcohol: Only 1 to 3 respondents had been involved sometimes in such control or regulatory activities like licensing of drinking places, liquor production and marketing, and law breaking. Two out of three involved with law breaking belonged to the GYR group.

5. Their involvement in the development of health and alcohol policy, locally, nationally and in the profession: Practically none of the respondents felt that they had any role in the development of health and alcohol policy. Only 2 and 1, respectively, had been involved with local policy makers and professional associations as regards health policy. None felt that he/she had any involvement in alcohol policy at any level or had much say with the national policy makers or even with professional associations.

6. Their involvement in specified (and other) health and alcohol research: Here again, the contribution of the respondents had been modest. Three (all from the GYR group) had been involved in general health research, but none had been involved in alcohol research. Their involvement in general health research was primarily as collaborators in the research activities undertaken by major medical institutions, especially the institution of the investigators.

7. Their actual experience of the other categories of health practitioners: Although the question pertained to their actual experience of other practitioners involved with problem drinkers, the response of the
general practitioners pertained to what they thought of as common knowledge and common sense as to what categories of people could be involved with the problem drinkers. Accordingly, most of the respondents were unable to name specific people to illustrate their involvement. 70.4 per cent thought that psychiatrists could be helpful, 48.1 per cent thought of medical assistants and 44.4 per cent and 29.6 per cent could see a role for nurses and traditional healers, respectively, in problem drinkers.

8. **Their assessment of the extent of the various specified (and other) alcohol problems in the country:** Although this question pertained to their overall assessment of such problems at the national level, their response mirrored their actual experience of involvement with alcohol–related problems. However, with regard to each problem, their assessment of its extent at the national level was higher than their actual involvement in it. Of the various problems, intoxication, road accidents, dependence–syndrome, family problems and financial problems (in that descending order) were rated as the highest and domestic accidents, public violence and domestic violence as the lowest.

9. **Their response to three hypothetical typical alcohol–related problems:** The respondents were asked to indicate their treatment responses where it concerned each one of the following three typical alcohol–related problems:

(a) "One of your recent patients, a young married man, comes to see you. He admits difficulties at work and at home caused by his drinking habits and asks for your help";

(b) "One of your patients has a minor accident and you are called to assist. Whilst you are attending to your patient you smell drink on his breath";

(c) "A new patient comes to see you complaining of stomach pains. On examination you discover a damaged liver and physical evidence of heavy dangerous drinking".

Treatment response to three typical situations was rated. The response of the respondents appeared to be quite appropriate. However, some were unable to give simple responses like discharging first aid for injury and recommending complete examination and investigations for the patients with stomach pains. It appeared that at times they were drawn too much by the alcohol aspect of the situation.

Many respondents were able to give examples of other ‘typical’ alcohol–related situations like unconsciousness, gastritis, financial problems, cerebrovascular accident, arrest for misbehaviour in public, excessive drinking at a party/festival, drinking due to family problems and head injury. One wondered as to what should be our intervention with relatives seeking help.

A content analysis was carried out on the verbatim responses of the practition-

| Table 2 | Treatment responses on three typical situations (N = 27) |
|---------|--------------------------------------------------------|
| Case 1  | 17 | 13 | 14 | 44 |
| Case 2  | 7  | 4  | 11 | 22 |
| Case 3  | 19 | 12 | 8  | 39 |
| Total   | 59 | 65 | 70 | 194 |
ers. Table 2 gives the frequency of the typical responses of the entire group for each one of the three situations.

The most common responses were to reduce or stop alcohol intake, psychotherapy and education treatment of the physical problem (mostly for case 2) detailed evaluation and investigations (mainly for case 3), and psychoactive drugs and referral to a specialist (mainly for case 3). The least common responses were reassurance to family and friends and involvement of law enforcement agencies.

10. Their suggestions as to what three things that could be done in the country (a) now and (b) within the next five years to (i) improve the response of medical professionals to and (ii) to help prevent alcohol-related problems:

The respondents had considerable difficulties in appreciating the four separate but inter-related questions. Their responses to the four aspects were virtually similar.

A content analysis of the responses to the four questions was carried out (Table 3). With regard to what could be done to improve the response of medical practitioners, now or in the next five years, the most common response, was to recommend education for the general practitioners. The other responses included operation of special clinics, and undergraduate medical education in alcohol and drug-dependence. As to what could be done now or within five years to help prevent the alcohol-related problems, the most common recommendations were to regulate production (to curb illicit production, to market less potent drinks of cheaper rates, quality control) and to organise public health education programmes through mass media and in schools and colleges.

Discussion

In an earlier study on a random sample of the general population (Varma 1980) we have reported that 11.2 per cent of the total subjects consumed one or more pegs (of spirit or equivalent) per week and have suggested that they can possibly be taken as regular users. In our study, we also inquired into a number of symptoms
which may indicate alcohol-related problems. Of the current users, 6.6 per cent admitted to remaining intoxicated for 48 hours or more at a time, 4.1 per cent of physical fights, 4.1 per cent of inability to work, 3.3 per cent reported physical and 1.6 per cent psychological illnesses due to drinking. 1.2 per cent admitted trouble with the police and 2.9 per cent having had trouble with their job. However, only 0.4 per cent had sought medical treatment. The current users, in turn, represented 23.7 per cent of the total sample of 1031. Hence, it can be said that possibly the prevalence of alcohol-related problems giving rise to problems investigated in the present study was significant though modest.

In another study, Malhotra et al. (1978) reported that 2.8 per cent of the total population in a year at a large teaching hospital were alcoholics.

Although the above figures are modest when expressed in terms of percentage, when translated into actual numbers they represent a considerable public health problem. It is quite possible that the low frequency of involvement of the general practitioners in their treatment was, in addition, partly on account of perception in the general population of alcoholism as a personal rather than a medical problem and partly possibly on account of their approaching facilities other than general practitioners (e.g. specialists, indigenous practitioners, etc.) for management of their alcohol-related problems.

It is obvious that the specialized inpatient and outpatient drug-dependence treatment units cannot cater to all the needs of patients with alcohol-related problems. Firstly, it is neither necessary nor desirable to subject all such patients to treatment at the specialized units as most do not require inpatient treatment and even otherwise it would be preferable if the treatment is made available in the community itself. Accordingly, it is obvious that the general practitioners will have to play a large role in the treatment of alcohol-related problems in the community. This requires considerable inputs in terms of training of the general practitioners in recognition and treatment of these problems. The approach of augmenting the treatment resources at the level of general practitioners would further be consistent with the current idea of integrating treatment of alcohol and drug dependence with the general mental health and other health services in the community. In addition, the general practitioners should play a larger role in the education of junior professionals, para-professionals, and other community resources and leaders in the identification and management of alcohol-related problems at their levels. General practitioners can and should be encouraged in leadership roles in policy decisions regarding the delivery of services, control and regulation of alcohol, larger policy decisions and research.

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