Alcohol and Injuries

I appreciated the Editorial by Brewer and Sleet[1] pointing out (again) the massive effect of alcohol on our societal problems, such as motor vehicle crashes, fires, drownings, suicide, and interpersonal violence. Some studies indicate that it is also a major factor in approximately 50% of crimes. I also appreciated their call to action to support "public policies such as strengthening laws that limit the availability of alcohol to underage youth and that reduce drinking and driving." I have formulated a proposal for such a policy that directly addresses the problem of restricting access to alcohol for those whose use of it causes harm to society.

Alcohol and its problems and pleasures have been with us for millenia. In this country, the 18th Amendment, which prohibited the manufacture and sale of alcohol, was an attempt to deal with those problems; however, it ended in even worse problems and so was abandoned. Prohibition failed because it deprived even those who could drink responsibly of the pleasures of alcohol, and so the black market was overwhelmingly active. We need to find a way of preventing those who harm others when they drink alcohol from getting that alcohol, while letting those who drink responsibly have access to it. There is no way to do this precisely, but alcohol consumption licensing has great potential to make valuable changes in that direction. There are various factors that need to be considered in developing a licensing plan.

1. Our current management mechanisms are not well tailored to address the problem. Often, alcoholics are induced or forced into treatment because of an arrest for driving under the influence. This is a good start, but there is also a penalty—we take away their license to drive. So we have an alcoholic struggling to get his or her life back together who now cannot drive to a treatment program or to work. Yet, he or she can still walk down to the liquor store, buy more alcohol, and continue to cause harm to self and others. This is especially true if, in an alcoholic stupor, he or she decides to drive without a license—an extremely common event.

2. Many alcoholics drink alone, partly to hide their drinking from others. Many others have difficulty finding anyone to buy alcohol for them; their sober friends and family would not think of it.

3. Most relapsing alcoholics and their families are incredibly ignorant of the nature of addiction, the effects of alcohol or other drugs, and the role of alcoholism in a wide array of social problems. The first part of a substance abuse treatment program is education in these matters.

4. Any restriction in access to alcohol will create, to some degree, a black market, so we need to be reasonably sure that the benefit to society outweighs the costs. This did not happen during the Prohibition era.

The best way to restrict access to alcohol is through an alcohol consumption license. In order to minimize the black market, the alcohol consumption license should be relatively easy to obtain and use, similar to a driver's license. The alcohol consumption license could be obtained after passing a test similar to a driver's license test, except that the knowledge required would be the physical and personality effects of alcohol, interactions with other drugs, genetic and other risk factors for alcoholism, the nature and early signs of alcoholism, the role of alcoholism in violent behavior, and the effects of alcohol abuse on children and other family members. This would essentially ensure that anyone who drinks alcohol would have also entered the first stage of treatment—education.

Since most people drink responsibly, the alcohol consumption license would only have to be renewed every 10 years or so, just enough so that the photograph looked approximately like the bearer of the license, and to update important knowledge. This would minimize the inconvenience to responsible drinkers.

The license would be suspended for anyone whose drinking has become a problem to society—driving under the influence, disability due to alcoholism, or any criminal or violent behavior while under the influence (including domestic violence). It could be reinstated in some circumstances for those who complete appropriate treatment. It would also be suspended for 1 to 6 months for anyone furnishing alcohol to someone without a license.

An alcohol consumption license would need to be presented before buying any alcoholic beverage in a store or bar or when more than two drinks or ½ bottle of wine (per person) are ordered with food.

It is often argued that those whose license had been suspended would just find someone to buy alcohol for them, but would they? A functioning alcoholic who has lost his license would be somewhat shy about asking his friends to buy alcohol for him—what if they ask why he lost his license? A responsible drinker would not be inclined to buy alcohol for someone without a license because it means that the person has a problem with alcohol, and "friends don't let friends drive [or get] drunk." An alcoholic would not want to risk losing his or her own license by buying alcohol for someone without a license—addicts protect their own source of supply above all else. A store owner would no longer deliver alcohol to the

alcoholic who is too weak to get out—an event now more common than is usually believed. Certainly, there would be exceptions, but the social pressure preventing those who cannot drink responsibly from getting alcohol would be vastly increased, as would the general awareness of alcohol-related problems. Moreover, harmful behavior by those who act harmfully while under the influence would be greatly decreased. Those who are in treatment would be able to drive to work and to treatment programs, but they would not be allowed to buy alcohol.

Problems like those during the Prohibition era would be largely avoided, because the vast majority of consumers would still have easy access to alcohol. Even of those denied legal access to alcohol, only the most socially bankrupt would engage the black-market acquisition of alcohol; others would abstain or seek treatment, if only to get back their license.

This should not be a uniform national program for the following reasons: (1) legally, because of constitutional restrictions and (2) logically, because a reasonable variation for one state (eg, Florida) may be completely inapplicable to other states with different demographics (eg, Massachusetts or Montana).

I realize that there may be other suggestions or refinements and would appreciate any comments, suggestions, or criticisms. However, we need to do something that will be acceptable to the vast majority of our populace to bring the problems in our society caused by alcohol under control.

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1. Brewer RD, Sleet D. Alcohol and injuries. *Arch Fam Med.* 1995;4:499-501.

In reply

We agree with Hamilton that all persons who use alcohol should be informed of the risks associated with alcohol use and the importance of limiting alcohol consumption to moderate levels,[1] if indeed it is appropriate for one to drink at all. We also believe that it is important for clinicians to screen injured patients for alcohol problems and, when feasible, to obtain routine blood alcohol concentrations for these patients to provide a basis for clinical and public health interventions that will prevent future alcohol-related injuries. However, in the case of persons who drive while intoxicated, we strongly believe that clinical interventions must be combined with strict legal sanctions, such as prompt suspension of a person's driver's license, to prevent injuries and deaths in alcohol-related crashes.[2] While license suspension is no guarantee that a person won't drive, strong scientific evidence supports the effectiveness of strict license sanctions in preventing deaths due to motor vehicle crashes.[3] Furthermore, given that there are approximately 17 500 alcohol-related crash deaths in the United States each year,[4] the inconvenience to the person whose license is suspended is more than offset by the hazard that individual poses to society and to himself or herself.

Moving beyond the issue of alcohol and injuries, we have significant concerns about who would be responsible for providing medical oversight for the alcohol consumption license that Hamilton proposes. Clearly, not all persons who complete the educational program he describes should drink alcohol, either because of the risk of drug interactions or because of a strong family history of alcoholism. If the state were to grant these individuals a license, would it not be tacitly approving their alcohol consumption and thereby overriding good medical practice? Furthermore, under this schema, would physicians be responsible for reporting patients with alcohol problems to the state? If so, what implications would this policy have for patient confidentiality and for the ability of clinicians to obtain an accurate history of a patient's pattern of alcohol use? We believe that these and many more questions would need to be answered before we could safely conclude that Hamilton's alcohol consumption license would, "first, do no harm." In any case, we believe that by screening injured patients for alcohol problems, assuring they receive appropriate treatment, and obtaining routine blood alcohol concentrations on these patients, clinicians can do much now to prevent alcohol-related injuries and deaths and to facilitate the secondary prevention of alcoholism.

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1. US Preventive Services Task Force. *Guide to Clinical Preventive Services.* Baltimore, Md: Williams & Wilkins; 1989.
2. Brewer RD, Morris PD, Cole T, Watkins S, Patetta MJ, Popkin C. The risk of dying in alcohol-related automobile crashes among habitual drunk drivers. *N Engl J Med.* 1994;331:513-517.
3. National Committee for Injury Prevention and Control. Injury prevention: meeting the challenge. *Am J Prev Med.* 1989;5(suppl):123-127.
4. Centers for Disease Control and Prevention. Update: alcohol-related traffic fatalities—United States, 1982-1993. *MMWR Morb Mortal Wkly Rep.* 1994; 43:861-867.

Physician Patterns in the Provision of Health Care to Their Own Employees

The article by Sansone et al[1] in the August 1995 issue of the ARCHIVES was of interest. The authors clearly stated several potential boundary issues that exist when physicians provide health care to their employees.

Physicians in our clinic have experienced all of these issues. We would like to highlight two additional issues that our group experienced and that we believe complicated the provision of employee health care.

The first issue arose when the clinic chose a capitated health maintenance organization (HMO) health plan as the clinic's health insurance plan. The clinic's physicians were providers under this health plan. If employees chose to receive health care through our clinic, the clinic would receive two financial benefits: