Alcohol abuse

Thank you for raising the topic of alcohol use and potential harm, and the broader area of substance use (*AFP* December 2016).[1–4] Choosing the right words can influence the likely response of potential patients, patients and the wider community. The use of the expression 'abuse' in this context may be counterproductive. Many people who might benefit from some tactful discussion of their use of alcohol may be put off by the suggestion that their behaviour comes under the same category as 'child abuse', 'elder abuse' or 'sexual abuse'. The term 'abuse' has such negative connotations that these patients could assume it has nothing to do with them.

The terms associated with abuse refer to doing something quite inappropriate or possibly evil. The patterns of alcohol intake discussed in this issue are of concern, but perhaps do not call for the same moral outrage as someone causing psychological or physical harm to another person. The World Health Organization (WHO) highlighted this in 1981.[5]

'Abuse' and 'misuse' are unsatisfactory concepts within a scientific approach.

I wrote a letter to the editor in 1990 when *Australian Family Physician* (*AFP)* contained a series of one-page patient education sheets by Dr John Murtagh, including one headed 'Alcohol abuse'. Murtagh published my letter and later released a book of patient education sheets. He gave a new title to the one relating to alcohol.[6]

Taking alcohol by mouth is the traditional intended function. Alcohol intake can lead to a variety of unwelcome consequences, but these could be made clear by terms such as hazardous, harmful or dysfunctional use, which highlight the distinction between psychosocial impairment, and potential and actual harm. In other areas of life, the concept of overuse works fine to indicate too much use. I do not hear the term food abuse – 'overeating' conveys the notion well enough.

The alcohol industry may like to keep us thinking that most people are good, upstanding citizens, and that only a weak, immoral few get into trouble with their product. Using clearer, less pejorative terms can help general practitioners (GPs) get through to those we manage, who need to review their ways.

Christopher Wurm
GP and Addiction Specialist
Visiting Fellow, Discipline of Psychiatry,
University of Adelaide

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Discharge summary quality assessment tool

I would like to suggest a characteristic of hospital discharge summaries not mentioned by Mahfouz et al (*AFP* Jan–Feb 2017)[1] that I believe is important to general practitioners (GPs). In my experience it is very rare to see in a hospital discharge summary any acknowledgement that the patient arrived at the hospital with a referral letter from their GP. Instead, the narrative section of discharge summaries often starts with statements such as: 'Patient presented with … (symptoms)', as if they had materialised from a black hole outside the hospital's door.

This failure to acknowledge the GP's referral letter is particularly galling when the GP has written a thoughtful, concise account of the patient's immediate problem and treatment given so far, and included a comprehensive health summary that contains only relevant and current information.

Hospital summaries should make it clear who referred the patient to the hospital. They should also acknowledge and, where appropriate, comment on the information in any referral letter.

Dr Oliver Frank MBBS, PhD, FRACGP, FACHI
University Senior Research Fellow
Discipline of General Practice, School of Medicine, University of Adelaide;
General practitioner, Oakden Medical Centre, SA

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Reply

We would like to thank Dr Frank for his letter and the points raised, with which we fully agree.

It is also our experience to receive discharge summaries not acknowledging that the patient was initially referred to hospital by their GP. Furthermore, one of the authors noted that in some cases there is no mention of the GP's name on the discharge summary, which would read as, 'Dear Dr/Medical Centre . . ., your patient presented with . . .' .

This practice is, of course, frustrating to GPs, as there is no recognition of the role of primary care in making sense of undifferentiated presentations prior to

referring patients to hospital. We can only assume it is because of a strict discharge summary template and/or lack of experience in junior doctors who complete the discharge summaries.

We ought not to forget that there could be equal frustration on the side of hospital staff and specialists when they receive a referral from GPs with minimal or no information. This could provide a framework for further research.

Notwithstanding all this, the aim of our paper was to provide a comprehensive and useful checklist of items to be included in a discharge summary, helping to ensure patient safety and the continuity of care on discharge from hospital. This checklist is based on the current evidence and feedback from our surveyed GP participants. So, while we find the lack of acknowledgment frustrating, it is not related to the evidence or purpose of the paper and we would not, at this time, include it in our proposed quality assessment tool.

Carl Mahfouz MBBS (Hons), AMC, FRACGP
General Practitioner, Shellharbour, NSW; Regional Community Academic leader: Illawarra, Graduate School of Medicine, University of Wollongong, NSW; Illawarra and Southern Practice Research Network (ISPRN); Career Medical Officer, Port Kembla Hospital, NSW.

Letters to the editor

Letters to the editor can be submitted via:
Email: afp@racgp.org.au
Mail: The Editor, *Australian Family Physician*
100 Wellington Parade
East Melbourne, Victoria 3002, Australia