The Problems Created by the Alcoholic Driver in a Hospital Emergency Department

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INTRODUCTION

In presenting this contribution I have attempted to use the eyes of the new Intern or Resident Medical Officer.

The tot of Hospital brandy Sister in Casualty used to keep to dispense surreptitiously to the shocked motorist or the fainting young lady, is a remedy now fortunately discarded. However much one mourns and regrets its passing, one can only applaud the advance in knowledge of the science and management of injury which has forced the change.

On the other hand alcohol still has a significant — some would say staggeringly disturbing and disastrous — effect upon the clientele of an Emergency Department. Despite the fact that occasionally the mildly inebriated can provide some light relief to the serious business of the Department by introducing some festive comedy, it is rare indeed that the staff have the time nor the other patients the inclination to join him in his happy intoxicated state. Alcohol still is stored in Emergency Departments but now it is in unassessed quantities diluted with blood of varying groups, refrigerated and waiting patiently for analysis of its blood content in Forensic Laboratories.

Alcohol \textit{in vivo} affects an Emergency Department in three ways:

\textbf{Group 1 — Persons Affected by Alcohol who Attend Hospital and Cause Physical Disturbance or Management Problems.}

The degree of disturbance or inconvenience caused by these persons can vary from a situation which can be dealt with by a firm word and firm but definite eviction from Hospital to the patient who requires physical restraint and possibly sedation for an acute alcoholic state or D.T.'s.

Both these situations require not inconsiderable tact and diplomacy; lack of experience allied to youth and frequently membership of “Women’s Lib” or “the weaker sex” makes it all the more difficult for young Residents and Nursing staff to deal with the situation.

Any large cosmopolitan Hospital will inevitably attract its group of alcoholic adherents. The clientele will reflect the community, its standards and its social services. The numbers will tend to be greater in those Hospitals where special facilities are provided for the care and reception of these persons. Seaboard towns with large dock areas, and centres of dense population will also predispose to this situation.

The group includes the regulars, many of whom suffer from chronic cerebral deterioration. Many are epileptic, and many are well known to Ambulance, Nursing and Medical staff. Although Johnnie returning for the third time in four days, post-ictal and inebriated passes the clerk and other lay staff with the minimum of concern, it is hoped the medical and nursing staff recognise the potential danger of the concealed subdural.

Some are happy drunks; some are fighting drunks; some are always being hit, assaulted, robbed or knocked down by cars. They present with bruises and lacerations to the head and upper limbs, rarely with fractures and uncommonly with serious injuries. Yet they require

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nursing staff time, Doctor time, couch space and all the other paraphernalia, stationery, records etc. of an Emergency Department. All this is time consuming and tedious. It becomes dangerous when space is cramped, facilities are restricted, staff is limited in numbers and under stress. Blood, vomit, dirt, dressings all require clearing and disposal. At times, such patients are noisy and obstreperous, requiring extra pairs of hands to control, restrict and restrain.

Some of these patients can safely be permitted to sober up in the Department, or leave when relatively mobile, but anxiety for their future safety and immediate control takes a disproportionate amount of energy and time. Facilities for isolation in sound-proof rooms are of value. Recommendation for admission to a detoxification centre, or psychiatric Hospital may be appropriate in certain circumstances.

**Group 2 — Persons Affected by Alcohol to Such an Extent That Either They or Others Sustain Physical Injury**

This category of patients contains a number of different groups:

(i) Road crash victims — drivers, passengers, pedestrians. These may not be affected by alcohol, but the frequency with which alcohol is present has been responsible for the introduction of the current Victorian Blood Alcohol Regulations.

(ii) Alcoholics who fall, have fits, get burned, or are assaulted.

(iii) Victims of drunken brawls or assaults.

(iv) Victims, not infrequently members of a family, who are injured by drunks in a domestic fracas.

**Group 3 — Patients With the Physical or Psychological Effects of Longstanding Disease Caused by or Associated With the Ingestion of Alcohol**

This group involves many patients with cardiovascular, metabolic or central nervous system disturbances. Patients in Group 3 present primarily with medical or psychiatric problems for assessment, treatment as Outpatients or admission to Hospital for management. They also may present with a variety of other conditions, symptoms, injuries, and the alcoholic problem may be either a contributory factor to a generalised medical condition, or the basic problem in a patient with a specific isolated incident. It is estimated that 20–30% of all emergency admissions to this Hospital have some significant alcohol component in their medical problems.

**THE MOTOR CAR ACT 1958 AND THE MOTOR CAR (BLOOD AND BREATH SAMPLES) REGULATIONS 1971.**

Since midnight on Sunday/Monday 8th April, 1974 it has been a legal requirement in Victoria for blood to be taken for alcohol estimation, from all persons over the age of 15 years presenting to a Hospital as a result of a motor vehicle accident. To midnight on Sunday/Monday 23rd January, 1977, samples have been taken from 4647 patients, an average of 4.5 patients per day.

It is not possible to present detailed figures for the whole of this period. However, for the year 1976, 1606 samples were taken and 1093 results have been received. Of these, 850 were negative, 243 were positive for alcohol and 223 were over 0.05 mgm% (20.4%).

One in six of all drivers had been drinking and the same proportion had more than 0.05 mgm% of alcohol in their blood. One in five of all passengers, pedestrians and others had been drinking and the same proportion had greater than 0.05 mgm% in their blood.
Of the figures returned, one sample showed a level in excess of 0.5 mgm%, one in excess of 0.4 mgm% and seven in excess of 0.3 mgm%.

The three main objectives behind this Legislation have been stated as:

1. To reduce the road toll by providing sufficient penalty to discourage or deter the drinking driver; and to punish the drinking driver offender.
2. To assist the clinician in the management of the injured at the time.
3. To identify the problem drinker and offer him some treatment for his problem.

The number of requests for blood samples from Police for law enforcement is 134 (12.25%), the number of requests for blood samples from Patients is 19 (1.8%) and the number of requests for blood samples for clinical purposes is zero. Every sample has required at least 15 minutes of Doctor time, therefore medical time involved is in excess of 400 hours. Where have we got with these objectives considering the 400 hours of Doctor time, the unknown Police time, the costs of equipment and so on?

No clinician to my knowledge has asked for a blood alcohol on an injured driver, passenger or pedestrian. If he did, this Legislation does not provide the machinery to supply him readily with the result.

An attempt has been made to follow up some patients with potential alcohol problems by sending a letter to the patient's general practitioner when identified. Legal opinion, has been given that –

"This statement is defamatory since the plain and unmistakeable inference is that the patient is a man who is either a habitual drunkard or is well on the way to becoming one”.

"Moreover, even if the letter is not open to that interpretation we are of the view that to say that a man has, or even might have an “alcohol problem” is defamatory since it is calculated to lower him in the estimation of “right thinking men generally”.”

CONCLUSIONS

1. The enactment of the Motor (Car Blood and Breath Samples) Regulations 1971 gives evidence of an attempt to control the drinking driver problem.
2. Hospital Casualty (Emergency Departments) are significantly concerned in these regulations.
   Attention to the detail of the regulations in hospital Casualty Departments assists the Police in prosecuting the culpable drinking driver who has a concentration of alcohol in the blood above 0.05%.
3. The amount of staff time involved in the operation of these Regulations in hospital Emergency Departments is significant.
4. Community attitudes require changing before the other objectives of the blood alcohol legislation can be achieved, viz, identification of the problem drinker and particularly the driver with a drinking problem and the offer of treatment for his problem.
5. These regulations have not been of value in providing a clinical service to the Doctor treating the injured person.