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Why do general practitioners not screen and intervene regarding alcohol consumption in Slovenia? A focus group study

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Summary. *Aim:* To identify barriers influencing general practitioners' decisions regarding alcohol screening and brief intervention (SBI) in Slovenia.

Background: Slovenia occupies third place in a league of 51 European countries with respect to alcohol consumption. General practitioners in Slovenia have the majority of contacts with patients in primary healthcare but they rarely or never ask patients about their drinking habits.

Method: Six focus groups with a total of 32 general practitioners from different parts of the country were set up. Participants discussed varied topics and the most significant barriers were identified through qualitative analysis.

Results: The identified barriers were lack of funding, absence of societal support, lack of knowledge and guidelines, inadequate counselling skills, different interpretations regarding definitions of what constitutes an alcoholic beverage, lack of time, alcohol screening not considered to be an integral part of general practice, personal characteristics of general practitioners, patients' unwillingness to participate in SBI, and ethical dilemmas.

Conclusion: Lack of knowledge and guidelines, and inadequate counselling skills can be solved through educational programs. In order to change drinking habits, substantial changes in public and personal attitudes towards alcohol consumption, involving many partners, are necessary.

Key words: Alcohol drinking, screening, primary care, focus group research, barriers.

Introduction

General practitioners (GPs) have an important role in prevention and treatment of alcohol-related health problems. Approximately 60–80% of the practice population visits a GP office each year and nearly all patients visit in a period of five consecutive years. Within healthcare systems, GPs are considered key professionals for screening populations for alcohol drinking [1–3].

Brief intervention (BI) by healthcare professionals is an effective early response that can positively influence drinking behavior of patients. Interventions should be directed towards patients who exceed low-risk drinking limits and should be carried out before or close to the onset of alcohol-related problems [4]. BI includes information on the adverse effects of excessive use of alcohol, health benefits accruing from reducing alcohol intake, and information on low-risk drinking limits. It also includes feed-back on laboratory tests, support to reduce drinking, and distribution of self-help booklets or brochures to patients [5, 6].

Slovenia is a wine-growing country with 2 million inhabitants and falls within the group of WHO European countries that consume over 10 liters of pure alcohol per person per year (together with the Czech Republic, France, Germany, Ireland, Lithuania, Luxembourg, Portugal and Spain). Slovenia is also in third place overall for consumption of pure alcohol (after Luxemburg and Lithuania): that is, 16–17 liters per year per inhabitant over 15 years of age [7], 7–8 liters of which is unregistered alcohol production [8]. Screening and brief interventions (SBIs) are not widely provided in general practice in Slovenia although SBI is known to be a cost-effective method for decreasing the burden of excessive alcohol consumption on health and social services, and for reducing the level of alcohol-related harm in populations [9]. The majority of patients with hazardous and harmful drinking habits are not identified because GPs seldom ask about consumption of alcohol.

There are many factors responsible for the infrequent use of SBI in healthcare services [10]. Qualitative studies focusing on GPs' attitudes towards SBI and exploring barriers to the use of SBI have been completed in some countries [11–14]. However, in Slovenia no such research has been undertaken and the reasons why Slovenian GPs do not ask their patients about alcohol is not known, although it is clear that morbidity and mortality, as a direct result of alcohol, are high [15].

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The aim of the present study was to identify Slovenia-specific factors to explain the paucity of SBI in general practice and to suggest strategies for implementation of routine early identification and BI in problem drinking. A qualitative research study using focus groups was conducted to develop such strategies.

Methodology

Focus-group methodology was used to research GPs' attitudes, views and experiences. Group interviews of this type focus on communication about specific problems between research participants in order to generate data, and explicitly use group interaction as part of the method [16]. Such groups are suitable for studying attitudes and experiences and can systematically pursue research questions that are not easily answerable by experimental methods [17]. Group processes also help people to explore and clarify their own views in ways that would be less easily accessible in one-to-one interviews. A moderator leads the discussion, asks questions and is responsible for encouraging all participants to contribute and express their individual attitudes. An observer makes notes about interactions and non-verbal communication among participants. The conversations are audiotaped and transcribed after meetings. The ideal group size is between four and eight people and a session typically continues for one to two hours. Focus groups can be homogenous (similar age, same gender, similar educational structure) or not, depending on the topic of the research. The number of groups participating in any piece of research depends on the quantity of data required and also on when ideas become saturated: when no further ideas are arising the research work is concluded [16].

In our study we set up six focus groups: in four of them the participants were all working GPs and in the other two the participants were GP tutors/working GPs. We expected to acquire viewpoints on teaching and problems in practice skills.

GPs were randomly selected from the Institute of Public Health national physician register ($n = 523$); GP tutors were selected randomly from a list ($n = 61$) at the Department of Family Medicine, Medical Faculty, University of Ljubljana. Participants were contacted personally by phone and were derived from different part of Slovenia (rural, urban).

Many GPs refused to be involved in the focus groups, typically stating that alcohol issues are "a waste of time and money". Finally, a total of 32 GPs attended the groups. The aims of the study (to identify barriers influencing GPs' decisions regarding alcohol SBI) were explained to each participant during the initial phone contact.

At the beginning of each group discussion participants were encouraged to talk to one another and comment on each other's experiences and points of view. It was explained that there were no "right" or "wrong" answers. The moderator raised the following topics to be discussed:

- What are the barriers to systematic SBI?
- What measures could reduce alcohol consumption?
- What is the best strategy for screening and follow-up of patients who drink and what is the role of a GP?

The discussions lasted between 60 and 75 minutes. The moderator encouraged all participants to contribute in order to elicit as many answers to the main questions as possible, and the observer made notes on non-verbal communication. Conversations were audiotaped and transcribed after each session.

The texts were analyzed by two independent researchers, as the use of more than one analyst can improve both the consistency and reliability of analyses [18]. Texts were typically explored inductively using content analysis to generate categories and explanations. Indexing the data created a large number of units that were compared by both the researchers and a reconciliation of diverging viewpoints was resolved by discussion. These codes were further refined and reduced in number by grouping them together in different thematic frameworks using a process called constant comparison. In this process each item is checked and/or compared with the rest of the data. This inductive process enabled the setting up of analytical categories as they emerged from the data. The process was inclusive in that categories were added to reflect as many of the nuances in the data as possible.

Results

After familiarization with the data, identification of a thematic framework, and indexing, charting, mapping and interpreting, 11 categories of statements that hinder effective SBI in general practice were identified:

- Disagreement over the recommended limits to the number of alcohol units per day/week
- Different interpretations as to the definition of an alcoholic beverage
- Overload of GPs (insufficient time)
- Lack of funding
- Ethical dilemmas
- Inadequate counselling skills for alcohol problems
- Prevention of hazardous or harmful alcohol drinking is not considered an integral part of general practice
- Personal characteristics of the GP
- Absence of societal support
- Patients' unwillingness to participate in SBI for alcohol
- Lack of specific guidelines and implementation strategies

Disagreement over the recommended limits to the number of alcohol units per day/week. The consensually defined low-risk limits for alcohol in Slovenia are: men – 14 units a week (two units per day) and no more than 5 units per one drinking occasion; women – 7 units a week (one unit per day) and no more than 3 units per one drinking occasion. One unit of alcohol beverage contains 10 g of pure alcohol in Slovenia.

GPs were sceptical about whether these limits are appropriate and correct. For example, they said, "Can drinking a little more really affect someone's physical or mental health?" They even doubted a direct relationship between small amounts of excess consumption and health problems. Clearly, they think that only heavy drinking is a threat to health, and thus by their standards it is difficult to distinguish between patients who drink within low-risk limits and those who exceed them.

> *"These are very sensitive things: we do not have data on whether patients who drink a little more have more health problems caused by alcohol consumption."*
> *"Every cigarette is harmful but every glass of wine is not. How do I persuade someone that it is OK to drink two glasses of wine but not two-and-a-half or three?"*

Different interpretations of the definition of an alcoholic beverage. GPs have different experiences of what their patients think about alcohol. Some alcoholic beverages are not regarded as such by their patients, thus some think that beer is just a thirst-quenching drink. Patients also think that wine is merely a type of food and that only spirits, such as brandy, are alcoholic beverages. These commonly held perceptions are hard to challenge and make doctors' tasks in SBI more difficult.

"It does not seem to people that beer is an alcoholic beverage; if they sweat a lot they have a right to drink a bottle of beer."
"Drinking one or two glasses of wine at lunch and at dinner is acceptable. It is a part of normal food."

Overload of GPs (insufficient time). The GPs said they see too many patients per day and SBI would represent an additional workload. They also thought that most patients drink excessively, so screening would increase the number of doctor–patient contacts because of the large number of drinkers who would need intervention. The high workload means there is genuine resistance to introducing innovative strategies into their daily routines.

"We must take into account our time, the number of patients, our burden, and so on. It is impossible to screen during normal working hours."
"If we had five patients a day, we could ask them everything and could manage every one of their problems. This way, it is impossible."
"If we started to manage patients that drink two bottles of beer a day, we could stop dealing with other illnesses."

Lack of funding. In primary care, the Health Insurance Institute of Slovenia covers only the costs that are defined in the national agreement and declines funding for any initiative outside this agreement. Systematic preventive work on alcohol problems is not a part of the agreement but should be paid for separately, as it involves additional work for the physicians. GPs need to have incentives.

"This screening is not valued at all, because they (government) do not think it is necessary."

Ethical dilemmas. Participating GPs believed that most drinkers do not have problems regarding social, family or professional life and health, and live like the majority of the population. GPs meant that they did not have the right to meddle in the lives of their patients. Questions about alcohol consumption could also embarrass a patient and may have a negative impact on the doctor–patient relationship.

"Why meddle in the family that is in order? We do not have the right or the duty. The duty, I think, is another issue; first of all we do not have the right."
"I do not know if it is good to ask everybody, we could destroy doctor–patient relationships."

Inadequate counselling skills for alcohol problems. GPs felt they were not acquainted with techniques for asking patients about alcohol use. GPs are educated in sophisticated diagnostic processes but in many cases do not feel skilled enough to lead a simple consultation.

"There are techniques (of communication) that are unknown to physicians – and here is a problem!"

Prevention of hazardous or harmful alcohol drinking is not considered to be an integral part of general practice. GPs are aware that prevention would be the best response to problematic drinking. However, since the national health policy has not recognized alcohol-related problems as important, there are no preventive programs in primary healthcare on this topic.

"Now, we are like firefighters: when there is a fire, we put the fire out. But we should offer a preventive program before a problem arises!"

GPs personal characteristics. Hazardous and/or harmful drinking by GPs themselves could be one of the reasons why they do not ask their patients about alcohol.

"It is a barrier when the GP drinks over the limit and in such cases he or she will not ask about patients' drinking habits. Or he/she does not have the appropriate attitude towards this problem."

Absence of societal support. There is no consistent national alcohol policy. Furthermore only a few national preventive programs on alcohol drinking have been conducted. The widespread belief is that abstinence is not normal; drinking alcohol is considered as a normal part of everyday life.

"Alcohol is an enormous source of income for the national budget and the government does not have any interest in cutting it down."
"Without the support of the government, I do not see good opportunities to screen and intervene."

Patients' unwillingness to participate in SBI for alcohol. The majority of patients follow the common attitude that drinking alcohol is a part of everyday life. They are not aware of alcohol-related risks and do not see the point of answering questions about their drinking habits.

"People do not think that such behavior (drinking alcohol over the limit) is a risky business. That is a problem."

Lack of specific guidelines and implementation strategies. Guidelines for many diseases are available, but guidelines for the management of problems related to psychoactive substances are lacking. As a result GPs do not know how to follow-up hazardous or harmful drinkers or which parameters should be checked on. The following should be clearly outlined: what questions to ask and when, how much time a GP needs for SBI, and what

parameters are taken into account in order to follow-up these patients.

"It should be exactly defined how to screen, how to follow-up and how to intervene. Screening is meaningless if we do not know what to do with such a patient."

Discussion

In Slovenia, GPs' attitudes regarding alcohol intake and SBI have not been previously researched. In this study we attempted to identify these attitudes using qualitative research methodology and focus groups. This produced a large quantity of data [18] and insight was gained into obstacles that make SBI difficult.

Unlike quantitative studies, qualitative sampling strategy does not aim to identify a statistically representative set of participants; it aims to derive participants who either possess certain characteristics, or live in circumstances relevant to the phenomenon being studied (theoretical sampling), to get as great a variety of statements as possible [19]. For this reason GPs who have daily contact with patients and some who also work with vocational trainees were asked to participate.

Sampling method weaknesses were reduced by extensive interactive discussions within the focus groups, using participants from different settings and continuing the discussions until all new ideas were exhausted.

Two independent researchers, each trained in qualitative analysis, provided analysis of the texts. Researchers have to be capable of perceiving a link between theory and data and must possess analytical skills to move towards hypotheses or propositions about the data. The use of more than one analyst can improve analytic consistency and reliability [18]; these were therefore assured in this study.

Although studies have shown that brief advice from primary healthcare professionals to hazardous and harmful drinkers can reduce their alcohol consumption by approximately 25% [20], GPs in Slovenia doubt that SBI can change patients' drinking habits.

In the UK, the average number of GP consultations in one week is 152 and they report that they are too busy to ask patients about alcohol [14]. In Slovenia, the average is 225 patient–doctor contacts in one week and this figure is likely to increase [21]. Clearly, this situation limits the time-frame available for additional GP activities. International research informs us that too heavy a workload restricts health promotion and doctors also refrain from participation in studies and projects on prevention [11–14, 22]. The same attitudes have proved true in this study. Reimbursement to GPs for time spent on alcohol prevention is not included in the government payment scheme.

Many studies have stressed that ethical dilemmas are an important disincentive for alcohol screening, because of the fear of intrusion into patients' personal lives [11–13, 23, 24]. This fear was also confirmed in the present study. Physicians' concerns about breaking doctor–patient relationships mean that screening and intervention practices may be less than optimal or may not happen at all. Perhaps GPs mask their own ambivalence [25] towards alcohol problems by citing ethical issues as an excuse. It is important to note the findings from other studies [26] demonstrating that patients expect to be asked about health risks. GPs should be aware that medical care is holistic, integral and ethical only if the whole person is treated [27]. The whole-person concept includes the use and misuse of alcohol, and this should be taken into account when screening. Sometimes patients who drink alcohol are considered 'heart sink' patients and that could also be a reason for not screening and intervening [28].

Lack of guidelines and the fact that doctors are not trained in counselling techniques are important reasons why GPs rarely screen patients for alcohol problems [3, 11–14, 22, 23, 29]. Friedmann et al. [23] found that confidence in skills and familiarity with guidelines contribute to better screening and intervention. GPs in Slovenia have received guidelines on alcohol screening, brief interventions and follow-up quite recently [30] but these are not yet widely known or sufficiently disseminated. A group of educators has been established in order to spread such guidelines and train GPs for SBI. Thus, alcohol prevention has been developed in exactly the way that was wished for by GPs in the focus groups: what to ask and when, whom to ask and how to intervene, how to manage problem drinkers and how to follow them up.

GPs' personal characteristics and lifestyles may also influence their attitude towards screening [31, 32]. GPs who drink over the recommended limits are probably less likely to ask patients about drinking habits. Alcohol use in Slovenia is a part of everyday life and GPs' own drinking habits probably reflect drinking patterns within the country. Consequently, GPs recognize risky behavior only in those patients who drink more than they do themselves.

Community and governmental support are of great importance in prevention [11, 24, 27, 33]. A national program for alcohol prevention in Slovenia was mentioned by GPs as an important prerequisite for greater acceptance of the role they could play in reducing alcohol-related problems. Unfortunately, there have been only a few alcohol-prevention projects in Slovenia [34], and an important barrier to SBI is that there is still no comprehensive national alcohol policy.

GPs in this study stressed patients' unwillingness to respond when asked about alcohol habits. Nevertheless, Kaner et al. [35] reported that only 3% of patients declined screening. Other studies have reported that patients had never been asked about drinking habits at all [1, 36]. In the present study, doctors' comments about patients' unwillingness to be involved in screening may be the result of patients being unrealistic about amounts consumed. If patients are asked about alcohol they tend to answer that they do not drink too much. The conclusion is that unwillingness on the part of patients to collaborate in SBI is not evidence based and would probably improve if physicians' attitudes changed.

The barriers in this study that have not been identified in other qualitative studies [11–14] are considered specific

for Slovenian GPs. They are as follows: disagreement over the recommended limits to the number of alcohol units per day/week; different interpretations as to the definition of an alcoholic beverage; and the fact that prevention of hazardous or harmful alcohol drinking is not considered to be an integral part of general practice. GPs doubt that the use of daily/weekly limits to assess low-risk and risky drinking are important aids to decisions on when to intervene. This viewpoint may result from the fact that some GPs themselves have alcohol problems, or it may be due to difficulties in calculating the number of units consumed when discussing these aspects with patients. GPs reported that people considered alcohol to be a food (wine) or a soft drink (beer), which obviously makes screening more difficult. Definitions of general practice/family medicine in Slovenia are well established [37]. Prevention is also defined, but incentives are not provided. The integration of alcohol prevention into everyday consultation in general practice remains a challenge for future governments.

The results in this study are derived from focus group interviews with a fairly small number of GPs and therefore some obstacles to SBI may not have been revealed. Nevertheless, the results provide valuable insights into barriers for SBI, and alcohol-related interventions may now be planned more effectively.

Alcohol appears to be a normal part of Slovenian culture. Indeed, drinking is sometimes even increased by beneficial health reports on alcohol; for example, comments that wine is good for prevention of cardiovascular disease. Broader community health approaches should therefore be developed to target, clarify and challenge such conflicting and misleading facts on alcohol use. Such measures will take years to prove effective in changing the deeply held cultural views on alcohol. Nevertheless, it is very important to change cultural attitudes on this issue in order to influence the individual's own behavior. There is also a need for a broader public health strategy involving many partners from different groups and professions.

Guidelines for SBI published in 2008 need to be implemented into practice more effectively.

At governmental level, health policy could improve acceptance of primary prevention of alcohol problems by incorporating it into GP contracts. To prompt this initiative the findings of this study were introduced to the Council for Alcohol Policy at the Ministry of Health.

Further studies should quantitatively measure the extent of reported barriers to alcohol SBI in family practice and the impact of interventions at different levels.

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Conflict of interest

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References

1. Aalto M, Pekuri P, Seppä K (2002) Primary health care professionals' activity in intervening in patients' alcohol drinking: a patient perspective. Drug Alcohol Depend 66: 39–43
2. Anderson P (2003) The risk of alcohol. What general practice can do. Drukkerij Quickprint, Nijmegen
3. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al (2003) Alcohol: no ordinary commodity. Research and public policy. Oxford University Press, Oxford
4. Aalto M, Seppä K (2001) At which drinking level to advise a patient? General practitioners' views. Alcohol Alcohol 36: 431–3
5. Anderson P, Gual A, Colom J (2005) Alcohol and primary health care: clinical guidelines on identification and brief interventions. Department of Health of the Government of Catalonia, Barcelona
6. Babor TF, Higgins-Biddle JC (2001) Brief intervention for hazardous and harmful drinking. A Manual for Use in Primary Care, World Health Organization
7. Rehn N, Room R, Edwards G (2001) Alcohol in the European Region – consumption, harm and policies. World Health Organization Regional Office for Europe, Copenhagen
8. Šešok J (2003) Alcohol consumption and indicators of alcohol-related harm in Slovenia in 2002. Institute of Public Health, Ljubljana
9. Wilk AI, Jansen NM, Havighurst TC (1997) Meta-analysis of randomized control trials addressing brief intervention in heavy alcohol drinkers. J Gen Intern Med 12: 274–83
10. Seppä K, Aalto M, Raevaara L, Perakyla A (2004) A brief intervention for risky drinking – analysis of videotaped consultations in primary health care. Drug Alcohol Rev 23: 167–70
11. Johansson K, Bendtsen P, Akerlind I (2005) Factors influencing GPs' decisions regarding screening for high alcohol consumption: a focus group study in Swedish primary care. Public Health 119: 781–8
12. Aalto M, Pekuri P, Seppä K (2003) Obstacles to carrying out brief intervention for heavy drinkers in primary health care: a focus group study. Drug Alcohol Rev 22: 169–73
13. Beich A, Gannik D, Malterud K (2002) Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners. BMJ 325: 870–5
14. Rapley T, May C, Kaner EF (2006) Still a difficult business? Negotiating alcohol-related problems in general practice consultations. Soc Sci Med 63: 2418–28
15. Šešok J (2004) Alcohol consumption and indicators of alcohol-related harm in Slovenia, 1981–2002. Croat Med J 45: 466–72
16. Kitzinger J (1995) Qualitative research: introducing focus groups. BMJ 311: 299–302
17. Meyer J (2000) Using qualitative methods in health related action research. BMJ 320: 178–81
18. Pope C, Ziebland S, Mays N (2000) Analysing qualitative data. BMJ 320: 114–6
19. Mays N, Pope C (1995) Rigour and qualitative research. BMJ 311: 109–12
20. Fleming MF, Barry KL, Manwell LB, Johnson K, Londonet R (1997) Brief physician advice for problem alcohol drinkers: a randomized controlled trial in community-based primary care practices. JAMA 277: 1039–45
21. Švab I, Petek-Šter M, Kersnik J, Živčec-Kalan G, Car J (2005) The cross-sectional study about GPs' work in Slovenia. Zdrav Var 44: 183–92
22. Andréasson S, Hjalmarsson K, Rehnman C (2000) Implementation and dissemination of methods for prevention of alcohol problems in primary health care: a feasibility study. Alcohol Alcohol 35: 525–30
23. Friedmann PD, McCullough D, Chin MH, Saitz R (2000) Screening and intervention for alcohol problems. J Gen Intern Med 15: 84–91

24. Cornuz J, Ghali WA, Di Carlantonio D, Pecound A, Paccaund F (2000) Physicians' attitudes towards prevention: importance of intervention-specific barriers and physicians' health habits. Family Practice 17: 535–40
25. Visserand OR, Smith AJ (2007) Young men's ambivalence toward alcohol. Soc Sci Med 64: 350–62
26. Wallace P, Haines A (1984) General practitioners and health promotion: what patients think. BMJ 289: 534–6
27. Unger F (2008) Health is wealth – toward a European lead market in health care. Acta Medico-Biotechnica 1: 11–8
28. Kersnik J, Kuralt M (2008) Are frequent attenders also heart-sink patients? Acta Medico-Biotechnica 1: 44–50
29. Geirsson M, Bendtsen P, Spak F (2005) Attitudes of Swedish general practitioners and nurses to working with lifestyle change, with special reference to alcohol consumption. Alcohol Alcohol 40: 388–93
30. Kolšek M (2006) Clinical guidelines on early identification and brief interventions. Medical Faculty, Department of Family Practice, Ljubljana
31. Frank E, Kunovich-Frieze T (1995) Physicians' prevention counselling behaviours: current status and future directions. Prev Med 24: 543–5
32. Kaner E, Rapley T, May C (2006) Seeing through the glass darkly? A qualitative exploration of GPs' drinking and their alcohol intervention practices. Fam Pract 23: 481–7
33. Susic TP, Švab I, Kolšek M (2006) Community actions against alcohol drinking in Slovenia – a Delphi study. Drug Alcohol Depend 83: 255–61
34. Kolšek (2006) http://www.fundacija-zgnz.si
35. Kaner EF, Heather N, Brodie J, Lock CA, McAvoy BR (2001) Patient and practitioner characteristics predict brief alcohol intervention in primary care. Br J Gen Pract 51: 822–7
36. Cohen E, Feinn R, Arias A, Kranzler HR (2007) Alcohol treatment utilization: findings from the national epidemiologic survey on alcohol and related conditions. Drug Alcohol Depend 86: 214–21
37. Kersnik J, Švab I (2004) European definition of general practice. Slovene Family Medicine Association, Ljubljana