Drinking up rugby

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We congratulate Andrew Swain and colleagues for their study of ambulance triage and treatment zones at major rugby events in Wellington. It is also worth commending Wellington Free Ambulance, Accident Compensation Corporation, and Wellington City Council to have the foresight to fund this undertaking.

The data is not surprising to anyone who is familiar with these types of events. The goal of reducing emergency department (ED) presentations is important for medical and economic reasons. The caveat is that it must be done safely. The parameters given for releasing patients are quite generous but arguably reasonable when trying to sift through sick patients. It would have been interesting to see if a breathalyzer would have changed the amount of patients held or their eventual disposition.

As mentioned by Swain et al there was no way of accounting for patients after they were discharged from the safe zones if they chose to present to ED. There were a number of patients who bypassed the ambulance service and self presented to the ED or in a few cases never made it to the event.

Wellington Hospital Emergency Department sees approximately 150 patients per day. Intoxicated patients can be difficult to manage and take up large amounts of resources and staff time. Differentiating sick from not sick is notoriously fraught with difficulties in the intoxicated patient. This is especially true when very little is known about the circumstances of the presentation for medical evaluation or when it is heard second or third hand.

Comparing the ED triage data for the two 24-hour periods (Friday and Saturday) of the Wellington Sevens Rugby Tournament (when there was a medical staffed “Safety Zone”) to when services were not available in the preceding 2 years demonstrates only a modest reduction in patient presentations. The percentage of total ED presentations related to the 2 days respectively of the Sevens for 2011 was 7% and 9% (without) and for 2012 was 3% and 4% (with Safety Zone).

Without the benefit of a “Safety Zone”, ED presentations related to the Sevens in 2009 were 8% and 10% and for 2010 the percentages were 7% and 11%.

Interestingly, the 2 days of the World Cup were only 1% and 3% respectively. Though the numbers are not large, it still presents a burden on a busy ED and any reduction in ED crowding and bed block is welcome. There are only 29 beds of which 20 are monitored and would be suitable for these patients.

Economically the analysis speaks for itself but it only scratches the surface. Described are the hard costs that are actually measurable. There are inferred costs that should also be considered. These include the cost of clerking, ancillary staff time, triage and nursing time, and physician time. There also is an intangible cost of just occupying a bed space. That is the cost of not being able to place a potential sicker patient in a treatment bed because it is occupied.
This cost is difficult at best to measure and quantify. Examples include the undifferentiated chest pain patient who has active coronary disease or a pulmonary embolus, the undefined septic patient, the subtle stroke patient, a sick child, or the patients who leave without being seen. Thus, the costs incurred as a medical system are far greater than actually calculated by Swain et al.

Swain et al described a culture of binge drinking around a specific event. Indeed, according to the Ministry of Health 25% of New Zealanders aged between 12–65 years binge drink. Moreover, market research has estimated that same number can be as high as 50%.

The relationship between sporting events and binge drinking is very clear and not unique to New Zealand. Binge drinking occurs and is a fact of life but this can also be a chance for an intervention in time of crisis. While it is doubtful that an intoxicated person would benefit from counselling at the time of presentation, prevention is a reasonable strategy. A clear message before the event may have some benefit. Anti-binge campaigns have been successful when directed to specific target audiences.

Campaigns against drinking and driving, promoting safe driving practices, and violence against women are visible parts of our society. It would be hard to argue that alcohol is not part of rugby culture. As a medical community can we help to curb that culture with an anti-binge campaign? Would a media campaign prior to the Sevens help change that culture?

There are many strategies to combat binge drinking at events such as barring entry to the stadium for those patrons who already significantly intoxicated, restriction of sales by time and amount, increasing the price, decreasing the ethanol content of beverages, raising the drinking age, and importantly restricting advertising and sponsorship opportunities.

Discussion of these topics goes beyond the scope of this editorial, however Swain et al demonstrate a clear public health issue and their paper is a unique addition to the literature. The savings described in this study are modest but enough to justify a campaign to reduce binge drinking that could benefit the public good.

Alcohol at rugby events is a given but moderation in consumption is a reasonable thing to strive for.

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