Abstinence will not be the goal for everyone, and relapse is common.\textsuperscript{2,4} When managing treatment of concurrent, and often related, chronic illness, interactions between medications and alcohol as well as changes in alcohol intake must be considered, and we cannot assume abstinence.

Lifestyle adjustments and psychosocial support are necessary.\textsuperscript{4} Indeed, when adequate psychosocial support was made available for Mervyn, the problems were stabilised, albeit at a significantly lower level of functioning and quality of life. The GP and social workers, in particular, played a critical role.

This raises questions about why this type of support was not accessed earlier. Each time Mervyn was hospitalised, he was either intoxicated or experiencing withdrawal symptoms. Yet, especially early on, alcoholism was not addressed in his treatment plan. While medical staff were cognisant of his alcohol problem, we are uncertain whether he was assessed by a physician with specific expertise in diagnosing and managing alcoholism. Certainly, his acute physical problems were severe, and thus the attention of health care professionals was tunnelled toward immediate, life-threatening issues. Did the doctors’ focus on repairing physical damage result in a tendency to overlook the psychological component of the addiction? As all of the health problems stemmed from alcoholism, were they treating the symptoms rather than the disease? Further, was the alcoholism just another symptom of a more fundamental problem? The situation can be characterised by a hierarchical symptomatology model in which diseases, or disease clusters, represent symptoms of an underlying issue. Indeed, it could be argued that all of Mervyn’s health issues stemmed from deep grief over the loss of his wife. Thus, grief led to accelerated alcohol abuse, which in turn led to a spectrum of physical problems.

If psychosocial support had been accessed earlier, would it have been possible to prevent or reduce the cognitive and psychological damage that led to the inability of the patient to engage and to be ready to change? This suggests that routine screening for problem alcohol use in middle-aged and older men, particularly following bereavement, would be beneficial. Certainly, patients displaying clear indications of a problem, as in this case, should be referred early to alcohol and drug services. It’s too late for Mervyn — but maybe in telling his story I can help save the life of another person.

Competing interests
None identified.

Author details
Jillian Dorrian, PhD(Psych), Senior Lecturer in Psychology
School of Psychology, Social Work and Social Policy, University of South Australia, Adelaide, SA.
Correspondence: jill.dorrian@unisa.edu.au

References

Konrad David Jamrozik
BMedSc, MB BS, DPhil, FAFPHM, FPFP, FPFAAA

KONRAD JAMROZIK WAS BORN ON 2 May 1955 in Leigh Creek, South Australia. He undertook basic medical training in Adelaide and Hobart, graduating from the University of Tasmania in 1977. After a year as an intern in Hobart, he won a Nuffield Dominion Trust scholarship to study at Oxford University from 1979 to 1982. There, he worked with Sir Richard Peto and the late Sir Richard Doll and produced a doctoral thesis examining strategies for promoting smoking cessation in general practice.

In 1983, Konrad lectured in Community Medicine at the University of Papua New Guinea in Port Moresby, where he was also a clinical assistant in the leprosy service. He took up a research fellowship in epidemiology at the University of Western Australia in mid 1984, and was promoted to Professor of Public Health in early 2000.

From December that year until September 2004, he held the Chair in Primary Care Epidemiology at Imperial College London. Later in 2004, he moved to Brisbane as Professor of Evidence-based Health Care and Head of the Division of Health Systems, Policy and Practice at the University of Queensland, then in 2007 became Head of the School of Population Health and Clinical Practice at the University of Adelaide. He also held short-term posts at the World Health Organization in Geneva, Harvard Medical School, the National Public Health Institute in Helsinki, Finland, and Jagiellonian University in Krakow, Poland.

Konrad had wide research interests including health promotion, the epidemiology and prevention of vascular disease, the design and conduct of randomised-controlled trials, and the translation of evidence into everyday practice. He had a natural talent for teaching and mentorship, helping to produce the next generation of health leaders. He also earned an international profile in the area of tobacco control as a researcher and advocate, and maintained a clinical commitment in medical oncology.

He was a prominent life member of the Australian Council on Smoking and Health and a Fellow of the Public Health Association of Australia. In 2009, he was awarded the Nigel Gray Award for his outstanding contribution to tobacco control.

Konrad was a dedicated cyclist and a keen rower who competed for Oxford and rowed for pleasure in rivers around Australia and the world. He was an unforgettable, extraordinary, dedicated man, and a loyal and caring friend and colleague with a commitment to excellence and justice. One colleague wrote, “It feels like public health in Australia has lost a limb”.

Konrad was diagnosed with advanced sarcoma in 2009 and remarked, in light of his work on cancer, that this placed him within “a tradition of doctors who fall victim to their disease of special interest”. He died in Adelaide on 24 March 2010 and is survived by his wife Lesley and children Euezebiusz, Harriet, Magnus and Aleksander, and his parents Adam and Ruth.

Terry Slevin and Euezebiusz Jamrozik

Obituary