



# Alcoholis

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## THE BULLETIN OF THE MEDICAL COUNCIL ON ALCOHOL

Committed to improving medical understanding of alcohol related problems

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This bulletin will be published quarterly. Items for publication to be forwarded to the Editor.

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### EDITORIAL

It is very reassuring to welcome back the MCA newsletter *Alcoholis* after an unfortunate necessity of absence of two years. In particular, the return reflects a distinct improvement in our finances. There is a degree of change in the format, and initially *Alcoholis* will be published quarterly with simultaneous publication on our website. Copies of the newsletters published from 1997 to 2003 remain on our website, and the office holds variable numbers of hard copies of most of these.

The intention is to include two articles per issue of about 1,000 words on related topics and, hopefully, from a wide variety of authors. Some of these articles will be reports of MCA activities, whilst others will review clinical and

social issues. The invitation to all members and others is there to write an appropriate article. Such articles will not be peer reviewed in the same way that journal papers are reviewed however; the MCA Office will hold editorial control and will retain the right to obtain independent comment as and when necessary, prior to publication.

MCA members will know of our new affiliation to the Royal College of Physicians of London, and *Alcoholis* is the first product of our association with the College and, in particular, its publication department. It is only right to acknowledge the assistance of Diana Beaven and her staff in resurrecting this publication. Long may this collaboration continue.

Dr G E Ratcliffe, Editor

### LECTURE

#### An enemy in their mouths (*Othello*, Act II, Scene III)



**Professor Peter Brunt**  
Chairman, Medical Council on Alcohol

Winston Churchill once observed that he had taken more from alcohol than alcohol had taken from him. Coming from a man of whom it is said that he drank a bottle of brandy and a considerable amount of champagne every day of the war, this must rank as a supreme example of the exception 'proving' the rule.

A well-known alcoholic actor drily commented that his last great gift to the country could have been his liver to wonder at. But such comments also demonstrate the colossal ambivalence that characterises society's view on alcohol and its problems.

For the past year, alcohol issues have remained much in the news, notably because of publication of the English Alcohol Misuse Strategy (Scotland's 'Action Plan' of 2002 antedated this) and the introduction of controversial licensing law legislation on both sides of the Border; Scotland's bill is completing its stage two in parliament.

The new licensing bill is to be welcomed; it is based largely on the recommendations of the

Nicholson Committee, the first major review since the Clayson report and the ensuing 1976 act. But licensing law is a fairly blunt instrument for tackling many of the problems of alcohol misuse and it is difficult to see how the radical changes of culture that the Alcohol Action Plan regards as essential will come about by legislation.

While the rising tide of 'binge drinking' (we have the second-highest rate in Europe) and accompanying disorder, violence and overwhelmed police and casualty services continue to dominate our TV screens, in the background, other indices of alcohol-related crime are increasingly alarming. Alcohol-associated deaths are rising. Alcoholic liver disease is especially worrying. In the

35–44 age group, the increase in deaths between 1970 and 2000 was more than 1,000 per cent. Cirrhosis is now being seen in 20 year olds. The Scottish Schools Adolescent Lifestyle and Substances Use Survey (2004) makes disturbing reading. A fifth of 13 year olds had had alcohol in the previous week and, of those, 53 per cent had been drunk at least once.

The toll of family and social disintegration worsens: between 30 and 60 per cent of child protection cases involve alcohol and it is estimated that up to 1.3 million children in the UK may be adversely affected by family drinking. Appalling and unnerving as the destruction of illicit drug usage is, it is dwarfed by alcohol in the impact on crime, health, social structures and

society as a whole. Alcohol is, indeed, Scotland's favourite drug; it is also one of its biggest destroyers.

So how is the problem approached? It is important to grasp three principles. First, most drinking is reasonable, responsible and largely risk-free – indeed, there is growing evidence that modest intake (two or three 'units' a day) may have some health benefits. Second, some

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**“ The difficulties associated with alcohol are well documented, but we still seem reluctant to take them seriously enough ”**

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drinking is unreasonable, irresponsible and destructive. Third, there is no sharp distinction between the two. True, there

are powerful determinants – genetic, familial, social, occupational. But the problem is as much a dimensional one as a categorical one.

Only a small proportion of heavy and problem drinkers are truly addicted-dependent. A major determinant of problems is the level of consumption. And this correlation of problems with the amount of alcohol drunk is true both at this individual level and at the level of the community as a whole.

All this means that tackling alcohol misuse must take place on two fronts: firstly, minimisation of harm by controlling situations, aberrant behaviour and specific risks (an example would be drink-drive measures and shatter-proof glassware) and targeting structured help to the seriously affected. Not surprisingly, this is the approach favoured by the drinks industry which maintains, with some reason, that most of the problem lies with a small number of people. Concentrate your efforts on the 'hard core' of alcoholics and do not penalise the great majority of reasonable folk enjoying themselves. The fallacy of this so-called 'preventative paradox' is that, in fact, most of the burden arises in the very large number of people drinking moderately over the advisory limits, albeit with a lower individual risk of problems.

Furthermore, there is now good evidence of a dose correlation between this mean per capita drinking in a community and the frequency of problem, or heavy, drinkers. Hence, measures to reduce overall drinking are the second approach. In recent years, compelling evidence has accumulated worldwide that such measures are the most effective in reducing the toll of alcohol problems. They include fiscal measures, ie increasing the tax, especially on strong alcohol beverages, and control of availability, such as reducing outlet density and hours of sale. Unfortunately, these are the least popular measures with government, with the beverage industry and with ourselves. What is more, less painful approaches such as health education have been universally disappointing. Alcohol has arguably become the greatest challenge to our

## MCA MCQs

### 1. The following drinks contain at least two units of alcohol

- A  1 pint of standard strength beer.
- B  175ml of red wine 12% alcohol by volume
- C  35ml measure of Scotch
- D  50 ml of sherry
- E  25ml of Drambuie

### 2. True or False

- A  The mutant allele of acetaldehyde dehydrogenase occurs in 40% of Orientals.
- B  The normal liver can metabolise two units of alcohol per hour.
- C  The blood alcohol level eight hours after a binge of 18 units over four hours will be above the legal limit for driving.
- D  In the UK alcohol is now 50% more affordable than 25 years ago in relation to disposable income.
- E  Alcohol-related accidents and injuries are associated with greater morbidity and mortality than all other alcohol-related disorders.

### 3. Violent incidents and alcohol

- A  Violent incidents most commonly occur in or around pubs and clubs.
- B  Alcohol contributes to 40% of domestic incidents.
- C  20% of people who visit pubs or wine bars three times a week are potential victims of violence.
- D  Muggings involve alcohol in 25% of incidents.
- E  Alcohol contributes to more than 50% of violent episodes involving strangers.

**Answers on back page**

community life. Also, it is the third in rank of risk factors for health in Europe (about 9 per cent of the disease burden). What is needed is a balance of the two approaches above. Harm limitation and targeting risk situations are important

Alcohol is everybody's problem and we cannot shelter behind the

comfortable image of the skid row, dependent alcoholic (only about 5 per cent of the heavy drinking population) as 'society's alcohol problem'. Neither the government nor ourselves wringing our hands will do. As Hamlet said: 'Diseases desperate grown by desperate appliance are relived or not at all'.

■ This article is published by kind permission of the *Scotsman* in which it was originally published on 11 October 2005. It is a summary of Professor Brunt's lecture to the Royal College of Physicians of Edinburgh, given on the same day.

## National Alcohol Awareness Day (NAAD)

**Jeff Battista, Technical Director of NAAD, describes an interactive challenge to medical students that teaches them the consequences of alcohol consumption**

This initiative was the brain child of Dr Steve Peters, the MCA Regional Adviser in Sheffield, who wanted to create a day to encourage medical students to think about their personal use of alcohol and the problems that this may cause them as a medical student and in their future careers as doctors.

He envisaged a learning tool produced in a contemporary medium that the modern student has embraced, viz the Internet and computer games. To this end an interactive challenge in the form of a computer game was developed, based on the diagnosis and treatment of patients with symptoms related to alcohol consumption. A range of patients with varying symptoms either recover or die based on the diagnosis and subsequent clinical actions. Each student received a password when first logging on which is used for all subsequent attempts.

Posters were produced in A3 and A4 formats to promote the game within medical schools. The design of the posters changed several times due to the evolution of the game interface and the necessity for the poster to reflect the visual identity of the game.

Each medical school was contacted via appropriate administrators, lecturers or support staff. This was not always easy and some verification of authenticity was required in some cases before proceeding. Once involved there was strong support. Posters were placed on

appropriate notice boards, and students were contacted via their emails, which was certainly very effective.

The prizes would be three or four short elective periods within well-known substance abuse treatment centres in the world funded by the MCA.

The game and website went live for a week in November 2005. There were a few problems with scripting bugs in the software and with database collection. The input of Drs Marsha Morgan and Elizabeth Hare in proofreading Dr Peter's original 100 questions was much appreciated.

The organisers had little idea of how successful this venture would be. The response was splendid, with over 2,700 individual students participating and contributing to over 4,000 hits on the website. Entries were received from 30 medical schools, with 47 students representing 18 medical schools obtaining full marks. An independent randomised draw took place to identify the four winners, listed below. Arrangements are in hand for the winners to spend three to four weeks in Vienna, Montreal, Seattle or Castle Craig. Brief reports from the winners of these

### Game winners

**Ms Adele Tinsley**  
University of East Anglia

**Ms Jennifer Hague**  
University College, London

**Mr Alvin Karsandas**  
University of Newcastle

**Mr Kheng Chiew Chooi**  
University of Glasgow



*Information leaflet promoting the National Alcohol Awareness Day.*

placements will be published in future issues of this publication.

The original proposal to develop a video and workshop to complement the game did not materialise. Such options may increase the number of entries in future projects. Nevertheless, the overall success of this project augurs well for the future.

### Editorial comment:

The success of this project is primarily due to the vision of Dr Steve Peters and his team, particularly Mr Jeff Battista and Ms Jo Milton. The MCA is much appreciative of their efforts, and formally acknowledges the financial support of the Alcohol Education Research Committee and the Garfield Weston Foundation without whom the project would have remained a pipe dream.

# Alcohol and Alcoholism

*Alcohol and Alcoholism* is the official journal of the Medical Council on Alcohol. It publishes papers on biomedical, psychological and sociological aspects of alcoholism and alcohol research. The journal also represents an excellent outlet for your research.

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## Alcoholis Publication dates

This bulletin will be published quarterly in March, June, September and December. Items for publication to be forwarded to the Editor.

## MCA MCQ answers

1. A True, B True, C False (1.4 units), D False (1 unit), E False (1 unit).
2. A True, B False (1 unit per hour), C True, D True, E True.
3. A True, B True, C False (10%), D False (about 17%), E True.



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The Medical Council on Alcohol is a small national charity committed to improving the medical understanding of alcohol-related problems

3 St Andrews Place, London NW1 4LB

Tel: 020 7487 4445 Fax: 020 7935 4479

Email: [mca@medicouncilalcol.demon.co.uk](mailto:mca@medicouncilalcol.demon.co.uk)

Website: [www.medicouncilalcol.demon.co.uk](http://www.medicouncilalcol.demon.co.uk)

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