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## Alcohol-related deaths by occupation

For several years reports concerning alcohol-related deaths by occupation have been produced by the Office for National Statistics. Such reports have identified medical practitioners as more likely to succumb to an alcohol-related illness compared to many other professions. The latest report for the 2001-05 period reveals a marked reduction in contrast with previous reports.<sup>1</sup>

A low standardised mortality ratio of 27 observed for male medical practitioners may be an artefact related to population counts from the 2001 census. Alternatively a proportional mortality ratio of 58 suggests a very real change in alcohol-related mortality for male doctors. In the 2001 census, 21% of doctors defined their ethnic group as Asian and this may have influenced the statistics. What has not changed

is the International Classification of Diseases listing of causes of alcohol-related deaths. Medical practitioners are now listed as 10th in the table of occupations least likely to succumb to an alcohol-related cause. These figures are encouraging and hopefully this improvement will be reflected in future surveys. A similar reduction in the numbers of practitioners reported to the General Medical Council because of alcohol problems would be equally good to see.

Of interest is the fact that four of the occupations listed with lower statistical rates than medical practitioners involved professional driving categories including drivers of heavy good vehicles, buses and taxis, ie occupations dependent on a valid driving licence.

Dr GE Ratcliffe, Editor

### References

- 1 Romeri E, Baker A, Griffiths G. Alcohol-related deaths by occupation, England and Wales, 2001-2005. *Health Stat Q* 2007;35:6-12.

## Safe. Sensible. Social.

This essay is written by the Editor as a stimulus to the debate that will be chaired by the MCA Chairman at the Annual General Meeting and Seminar on 28 November 2007.

The publication of the government's next steps in the National Alcohol Strategy, entitled, *Safe. Sensible. Social.*, is the stimulus to this essay. The report clearly states that more needs to be done to promote sensible drinking, and stipulates the following eight next steps in its strategy:

- sharpened criminal justice for drunken behaviour
- a review of NHS alcohol spending
- more help for people who want to drink less
- toughened enforcement of underage sales
- trusted guidance for parents and young people
- public information campaigns to promote a new sensible drinking culture
- public consultation on alcohol pricing and promotion
- local alcohol strategies.

## Sharpened criminal justice for drunken behaviour

The condition of being drunk and disorderly remains extant and warrants appropriate punishment. In some circumstances being drunk is given as a mitigating factor, and hence as an excuse for disorderly behaviour, rather than being the major defining cause. There are well-known explanations as to why alcohol and violence are linked including disinhibition, increased excitability and self confidence as well as preparedness to take greater risks. Nothing has changed in the affects of excessive alcohol intake. Non-enforcement of existing laws is surely a contributing factor to increasing drunkenness. Public notices banning the consumption of alcohol are not infrequent.

How often are they invoked, and, if so, how



*Typical signs in a Wiltshire town*

often are they enforced? Much has been written in the press recently about possible new laws, including raising the age at which people can purchase alcohol to 21. New laws will not necessarily be enforced any more than laws already in place and which, for whatever reason, have not been enforced.

Local constabularies perform valiant duties, particularly in city and town centres on Friday and Saturday nights, containing large numbers of young people who consume vast quantities of alcohol with the specific intention of getting drunk. Unfortunately many of these young people subsequently offend. Some licensees flaunt the law and continue to serve alcohol to those who are clearly inebriated. Selling alcohol to underage people also continues, although signs have appeared requesting people not to be offended if proof of age or identity is considered necessary before alcoholic beverages can be purchased.

### **A review of NHS alcohol spending**

A stocktake of the burden of alcohol-related harm on NHS resources is planned, the results of which will influence spending decisions, driving local investment in prevention and treatment while delivering better health and saving the NHS money. Much is already known, not least on the impact of alcohol on accident and emergency (A&E) departments. The government's decision to introduce 24-hour drinking in 2005 certainly

attracted criticism and censure. A recent report comparing overnight A&E admissions before and after implementation of this policy demonstrated significant increases in alcohol-related cases.<sup>1</sup> Despite this rise, however, overall numbers were less than in audits performed elsewhere: this might be due to the fact that the audit only included patients who had documented evidence of alcohol consumption before admission. Moreover, presumed inconsequential consumption was not documented. Anecdotal reports from elsewhere suggest variable effects of the change in the licensing law. Consistency in reporting is an issue which may well affect overall figures: an under estimate in such circumstances is the likely outcome. A 'seek and thou shalt find' attitude is necessary to substantiate accuracy of data. Geographical variation is obviously inevitable but only accurate data will allow local decisions to be made to reflect the medical needs of the population at risk.

A second recent report further illustrated this point.<sup>2</sup> There is no doubt that attendances in A&E provide an excellent opportunity to at least identify patients with alcohol problems. Formal screening tools are not utilised in many departments, which results in missed opportunities to at least influence alcohol consumption in many cases in the short- to medium-term, with a consequent potential fall in further attendances.

### **More help for people who want to drink less**

The strategy suggests that many people do not require, or want, professional help to reduce their drinking but will respond to simple advice from support groups, via telephone helplines or from an interactive website. Certainly such proposals are positive. In my experience, many calls we receive from the public and the media highlight ignorance about units of alcohol in certain drinks. Most wines contain 12–15% alcohol by volume so that a standard bottle of wine contains 9–11 units. Many couples will consume a bottle between them on a regular basis: five bottles per week is the equivalent of around 20 units each. Many are surprised when informed of their unit intake (spirits, of course, contribute more) and will hopefully reduce their consumption accordingly. One frequent cause for frustration is the annual question about how to prevent or cure hangovers around Christmas or New Year's Eve. Reducing the number of drinks consumed never seems to occur to the majority of those who make such enquiries.

### **Toughened enforcement of underage sales**

Local authorities and the police have heightened powers to prosecute and even close premises that persistently sell alcohol to children. Recently in Sussex a local branch of the largest UK

supermarket chain lost its licence to sell all alcoholic beverages for a month because it had repeatedly broken this law. Notices in supermarkets are possibly more apparent than before, stipulating alcohol will not be sold to anybody under the age of 18. What they do not say is what is likely to happen if you attempt to buy alcohol underage. A polite refusal in the first instance perhaps: less polite for subsequent attempts. But do supermarkets have a policy in place to implement tougher action? Similarly, off-licences should have policies in place but again they are not always easy to implement when six strapping 16-year-olds appear at once attempting to buy beer and there is only one sales assistant. Parental responsibility remains the key to this issue, as well as to many others. Some parents need firm reminders of the present laws surrounding alcohol and their children. The underlying reasons involved with underage drinking are multifactorial and beyond the scope of this essay, suffice to say that there is overlap involving many of the concerns within our society today and solving one issue will not necessarily produce the desired results if the other issues are ignored.

### Trusted guidance for parents and young people

Many young people drink alcohol with or without their parents' knowledge or approval. There have been several reports published which identify UK teenagers being close to, if not top of, the league regarding alcohol consumption when compared to most of their European counterparts. Introduction of children to alcoholic beverages is a parental responsibility: children who see their parents drink may be curious to try something similar. In a supervised setting small quantities as a taste would seem appropriate. Most alcoholic beverages are unpleasant to the untrained palate (possibly why alcopops were invented?) and as a result immediate curiosity may be satisfied. Unsupervised drinking in public by teenagers, however, continues to make the headlines, and results in more acute problems, social as well as medical. Regrettably cases of fatal alcoholic poisoning do occur,

particularly in naive youngsters who have had little or no experience of previous alcohol consumption. A tragic waste of a young life. The government will provide authoritative, accessible guidance about what is and what is not safe by engaging interested parties; by delaying the onset of regular drinking, primarily by changing the attitudes of 11 to 15-year-olds and their parents about alcohol; by reducing harm to young people who have already started drinking; and by creating a culture in which young people feel that they can have fun without needing to drink. Correctly the strategy identifies the need to provide information and guidance to parents and young people to allow them to make informed decisions about alcohol consumption.

### Public information campaigns to provide a new sensible drinking culture

The strategy suggests a new generation of publicity campaigns to emphasise sensible drinking and highlights the physical and criminal harm related to alcohol misuse. Previous campaigns have not necessarily been very successful. Furthermore a wide number of articles have recently appeared in the broadsheets suggesting that specific recommendations to reverse the trends in binge drinking will fail. The tabloids, particularly those distributed freely on a daily basis in the capital, regularly depict supposed celebrities in various degrees of inebriation the previous night. Such reporting is extremely negative and suggests that binge drinking is 'harmless fun'; accordingly to Mr Clarkson it is actually good for you.<sup>3</sup>

### Public consultation on alcohol pricing and promotion

The strategy proposes an independent review of the evidence, followed by a consultation beginning in 2008 to explore the relationship between promotional activity and harmful consumption. Proportionately, the cost of alcohol has not risen over the last two decades in the same way as the cost of tobacco. Evidence suggests that cost does materially affect consumption. Proposals by

epidemiologists, among others, to raise prices of alcoholic beverages, however, are greeted with much cynicism and objection. Minor increases, particularly as seen typically in the budgets, are mere chicken feed and will have a marginal affect on consumption at best. Major increases in price would be necessary to have significant impact on consumption. But what amount of increase? £5 on a bottle of spirits, £2 on a bottle of wine, 50p on a pint of beer? Would such rises have the desired effect? Politically, vast increases are considered unacceptable by many. Certainly not a great vote winner.

Retailers, particularly supermarkets, treat alcoholic beverages in the same way as other commodities. Promotions of alcoholic beverages, for example 'buy one, get one free', are frequently seen. Some of these offers are ridiculously cheap with units of alcohol costing as little as 25p: it is equally ridiculous to suggest that alcohol consumption by some is not increased by such offers. Advocates who encourage reduction in consumption strongly favour price rises to achieve this aim. One argument against this proposal is why penalise the majority who consume sensible or responsible amounts of alcohol because of the minority? This is a cogent argument. Of course it is utterly impractical to vary costs dependent on individual consumption, but it is more practical to institute consistency of price of alcoholic beverages no matter the source of purchase.

This debate will continue. A recent study from the Cardiff Business School reviewed the impact of the price of beer on violence-related injury.<sup>4</sup> The report concluded that substantially fewer violent injuries, and consequentially a reduction in demand on trauma services, would result if prices increased. It is hoped that this statistically significant evidence will feature in the government's review of the evidence.

### Local alcohol strategies

Quite correctly the new strategy identifies local communities as being in the best position to tackle local problems, including alcohol-related disorder. The stipulation therefore that

by April 2008 all crime and disorder reduction partnerships including police, local authorities and primary care trusts in England will have a strategy to tackle crime, disorders and substance abuse is to be encouraged. This is, however, a big demand in a relatively short time and achieving this goal without difficulty is very optimistic. Progress will be followed with a keen interest. In summary, much remains to be done to make progress in many key areas.

Determined input from organisations working collaboratively is necessary. One interesting statistic to be remembered is that the average consumption of pure alcohol by each citizen of the UK has risen to nine litres per year. That is the equivalent of 900 units and an average daily consumption of nearly 2.5 units. If this level was a true reflection of consumption in society many of the problems associated with alcohol would potentially disappear.

#### References

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- 3 Clarkson J. Binge drinking is good for you. *Sunday Times* 2 Sept 2007.
- 4 Matthews K, Shepherd J, Sivarajasingham V. Violence related injury and the price of beer in England and Wales. *Applied Economics* 2006;38:661–70.

#### Disclaimer

The views in this essay are not necessarily those of the MCA who, nevertheless, welcome comments from other parties. This subject will be debated during the MCA seminar on Wednesday 28 November 2007.

## MCA MCQs

### 1. Alcohol abuse and eating disorders – True or False

- A  In various studies about 20–25% of patients with bulimia nervosa have a history of alcohol abuse or dependence.
- B  Similarly about 5% of patients with a tendency towards anorexia nervosa have a history of alcohol abuse.
- C  The co-occurrence in all cases is random.
- D  Patients with bulimia nervosa and alcohol abuse or dependence have a worse prognosis than those who do not.
- E  Cognitive behavioural therapy may be helpful to treat both the eating and alcohol disorder in combination.

### 2. Hypertension and alcohol – True or False

- A  An association between heavy alcohol consumption and hypertension was first reported in French servicemen during World War One.
- B  Episodic drinking patterns are more likely to accentuate the fluctuations in blood pressure due to alcohol.
- C  The severity of detoxification-withdrawal syndromes is related to the level of blood pressure.
- D  Abnormal renal handling of salt does not contribute to alcohol-related hypertension
- E  There is no clear association between smokers and non-smokers in patients with alcohol-related hypertension.

### 3. In classic alcohol-associated polyneuropathy – True or False

- A  Symptomatically predominantly sensory and distal distribution.
- B  Affects the upper limbs before the lower.
- C  Permanent abstinence from alcohol is an essential prerequisite for any improvement
- D  Autonomic fibres may be involved.
- E  An acute form in chronic alcoholics may occur and which may be associated with Wernicke's encephalopathy.

### 4. In alcohol poisoning – True or False

- A  A lethal dose of alcohol is said to be 3 g/kg for children.
- B  Hypothermia is a frequent associated finding.
- C  Haemorrhagic erosive gastritis is rare.
- D  Associated acute hypoglycaemia has been proven as a cause of death in young children.
- E  Associated hypothermia is partly mediated by hypothalamic failure to compensate the body temperature.

**Answers on back page**

## The Max Glatt Memorial lecture and medal

Last year the MCA Executive Committee decided to establish an annual memorial lecture in honour of the late Dr Max Glatt, one of the founder members of the MCA and a pioneer in the development of services for alcohol dependency in the UK.

Dr Spencer Madden, Vice Chair of the MCA until 2006 and a one time colleague of Dr Glatt, was invited to deliver the inaugural lecture to conclude the 2006 Annual General Meeting (AGM): a transcript of his lecture will appear in the 2007 Annual Report. In future years a highly respected health professional within the world of alcohol and medicine will be invited to deliver a lecture on an appropriate topic to close the AGM.

The lecturer will receive an engraved commemorative medal. The medal (Fig 1) was designed by the Medical Director in conjunction with Garrards: the profile of Dr Glatt was produced from a photograph kindly provided by Mrs Glatt. Our thanks are due to her for agreeing to support this initiative and for sanctioning the final design. Having presented the inaugural medal to Dr Madden, Mrs Glatt was similarly presented with a commemorative medal by the MCA President, Sir Michael Marmot.

Fig 1 (above and below right). The Max Glatt Memorial Medal



## Annual General Meeting and Seminar 2007

This Annual General Meeting (AGM) and seminar will take place on Wednesday 28 November 2007 in the Council Chamber of the Royal College of Physicians. Our new President, Sir Michael Marmot, will be in the chair.

The second Max Glatt Memorial lecture, which will be the last item of the AGM, will be given by Professor Roger Williams. His lecture will be entitled, 'The pervading influence of alcoholic liver disease in hepatology'.

10.30 Tea and coffee

11.00 **AGM**

12.30 Lunch

13.30 **Seminar: specific issues relating to alcoholic liver disease**

Susceptibility to alcoholic-liver disease: genetic constitutional and environmental factors

**Dr Marsha Morgan**

Serum markers of alcoholic and non-alcoholic steatohepatitis

**Professor William Rosenberg**

Pharmacological approaches to alcohol dependency in concomitant alcoholic-liver disease

**Dr Ken Checinski**

A debate on the government's latest alcohol strategy, *Safe. Sensible. Social.*, will follow introduced by **Professor Peter Brunt**.

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Posters advertising the competition have been distributed to medical schools throughout the UK.

**Alcoholis publication dates**

This bulletin will be published quarterly in March, June, September and December.

*Items for publication should be forwarded to the Editor.*

**MCA MCQ answers**

1. A True, B True, C False, D False, E True.
2. A True, B True, C True, D False, E True.
3. A True, B False, C True, D True, E True.
4. A True, B True, C False, D True, E True.



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

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