FOUNDED 1967

ISSN 1351–0541

Alcoholis

THE BULLETIN OF THE MEDICAL COUNCIL ON ALCOHOL

Committed to improving medical understanding of alcohol-related problems

Volume 29
Number 3
September 2009

In this issue

Editorial 1–2

Doctors and mental health

RSM conference – Alcohol and the adolescent: addressing the binge society

Medical students' attitudes to alcohol: early intervention 2–5

Alcohol, sexual behaviour and sexually transmitted infections 5–6

AGM notice 6

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

© Medical Council on Alcohol 2009

MCA
5 St Andrews Place,
Regent's Park,
London NW1 4LB
Tel: 020 7487 4445
Fax: 020 7935 4479

Registered Charity Number 265242

FROM THE EDITOR

Dr Guy Ratcliffe

Doctors and mental health

Doctors' attitudes to becoming mentally ill remain a cause for concern. In a recent postal survey of 3,512 doctors in Birmingham, 1,807 of the 2,462 doctors who responded said they would disclose mental illness to family and friends rather than to a health professional, with 800 citing career implications as the most frequent reason for failure to disclose. Of those who responded, 12.4% had experienced a mental illness. It was generally believed that there were no clear guidelines for doctors to follow for mental health care.

The survey was carried out by Hassan *et al*,[1] who made the following recommendations:

- Education on mental health stigma and its consequences should be more prominent in medical schools, and on training courses for junior doctors.
- A mandatory component of junior doctors' training should include awareness of physicians' impairment and substance abuse management.
- Medical school curricula could incorporate training on consultation skills for situations in which the patient is also a doctor.
- Further education is required for training medical students and doctors in the detection of mental illness at an early stage.

These proposals would seem appropriate but how practical are they? The pressures on junior doctors seem bound to increase, with the demands of the European Working Time Directive among others. Nonetheless these items must not be ignored: the Physicians Health Programme has now been running for nearly a year and an audit of its activities will make interesting reading.

RSM conference – Alcohol and the adolescent: addressing the binge society

The recent Royal Society of Medicine conference on alcohol and the adolescent included much discussion, predominantly from doctors. Unfortunately input from the police and the alcoholic drinks industry did not materialise. One interesting observation was that the calculated cost of managing a drunk person with a head injury in A&E for four hours was £490: this figure included an ambulance call-out fee of £250.

A major review of alcohol advertising was called for, not least in cinemas and on TV. Support for policies curtailing advertising is very scanty outside the medical profession and charities concerned with alcohol misuse. Similarly sponsorship of major sporting events remains very contentious.

Published around the same time as this conference was the British Medical Association (BMA) report, *Under the influence*,[2] about the damaging effect of alcohol marketing on young people. This document is free for BMA members. In summary, it recommends the minimum price levels for alcoholic products, a reduction in licensing hours, further evaluation of sales practices, and a comprehensive ban on all alcohol marketing communication. Most important of all, it urges all the UK governments to move away from partnership with the alcohol industry and look at effective alternatives to self-regulation. It seems to

Continued overleaf

me that our society must focus on developing an all-embracing set of proposals to reduce alcohol-related harm to which we must all aspire. The appointment of an independent alcohol tsar would be a good start.

In this issue ...

The paper from Bristol University about medical students' attitudes to alcohol describes an excellent attempt to educate some of our future doctors about their own consumption at a very early stage. Perhaps other medical schools should follow suit: or perhaps they have different methods already in place, in which case we should like to hear from them.

A present issue of concern relates to the fitness to practice guidelines which students about to qualify must complete. Alcohol related issues figure as possible obstacles to fitness to practice: such issues may be prolonged if definitive guidelines are not followed or are implemented only after inordinate delay.

The links between alcohol and sexual behaviour are supposedly well known: yet, surprisingly, little has been formally written. The paper from the genitourinary medicine department in Southampton goes some way to correcting this. In particular their prospective study, albeit small, identifies the impact of alcohol on drug compliance and further casual sex.

References

1 Hassan TM, Ahmed SO, White AC, Galbraith N. A postal survey of doctors' attitudes to becoming mentally ill. *Clin Med* 2009;9(4):327–32.

2 British Medical Association. *Under the influence: the damaging effect of alcohol marketing on young people*. London: BMA Board of Science Publications, 2009.

Alcoholis publication dates

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

Medical students' attitudes to alcohol: early intervention

Tim M Williams, clinical lecturer, Simeon Rackham, medical student and Ben J Watson, clinical research fellow

University of Bristol

Introduction

Medical students face a long, arduous and hopefully rewarding challenge at university. Students must be successful in examinations and assimilate knowledge and competency in a variety of clinical skills. They are expected to arrive at the end of their studies ready to deal with the general public as foundation doctors. Medical students must now act not only with complete competence but also with probity, a quality highlighted by the General Medical Council (GMC) as essential for good doctoring. In 2005 the GMC and the Medical Schools Council established the joint Student Fitness to Practice Working Group which has developed guidance for medical schools and medical students.

Doctors are at risk of developing drug and alcohol dependencies, perhaps because of the stressful nature of the work but also because they have access to potentially addictive substances. Doctors are at greater risk of alcohol-related death.[1] There is often reluctance for doctors to seek appropriate assistance, possibly because the system is perceived as disciplinary.

Substance dependence can begin during medical school and there is increasing concern about the relationship between university student lifestyles and alcohol. There have been recent, well publicised incidents involving student initiations and extreme alcohol intoxication. University life is a rich tapestry full of societies, social activities and many friendships, but it is a tapestry that increasingly features alcohol as a main theme interwoven through these other threads of university life.

At the University of Bristol we have developed an intervention programme to address drug and alcohol use when students first enter medical school. We have positioned this within the vertical theme entitled 'Professional Attitudes and Behaviours' running throughout the medical student curriculum. The aim is to encourage self-awareness, signpost places to seek help, enhance willingness to seek help for oneself or to guide others, and to break down myths of an unsupportive structure and highlight positive outcomes. We will first describe the approach used and then report on the findings collected during the intervention.

The educational intervention

It was agreed that it was important to position the intervention during the first week of lectures in order to highlight the importance of probity from the first day of students' medical careers. Alcohol-focused teaching appears throughout the five-year medical school curriculum initially focusing on students' own behaviours, through to treatment of drug and alcohol dependencies based in their psychiatry attachment, and then medical consequences in junior and senior medicine in years four and five respectively (Fig 1). The theme of professional behaviour runs parallel to

this throughout the five years. Examinations on drug- and alcohol-related issues take place mainly in years three and five and may take the form of a viva, patient management problems, observed structured clinical examination, and multiple choice and extended matching questions.

GMC-based lecture. The first element is a lecture from a doctor who sits on the GMC Fitness to Practice panels. The structure and function of the GMC is outlined as well focusing on cases of doctors referred for drug and alcohol problems. The supportive element is emphasised.

Educational Quiz. This takes the form of an interactive lecture. Students have electronic voting panels and the results are flashed up immediately on the screen. This allows us not only to get the students thinking about their own behaviours but enables us to anonymously collect data. The lecturer asks the students to rate their own drug and alcohol consumption and also tests their knowledge of guidelines and their ability to quantify alcohol use. The students' consent is obtained to use the data; the data of those who do not consent are excluded from the analysis.

Testimony from a doctor with alcohol dependence. The lecturer covers their own addiction to alcohol, attempts at hiding the problem, how it was eventually discovered, and the impact on their medical career. The lecture finishes by acknowledging what they had found most helpful, how they were presently coping and advice for the first year students about their own careers and the necessity of probity.

Testimony of service users. In the year three of the curriculum medical students undertake their psychiatry attachment. Each academy is asked to facilitate a small group discussion between the medical students and one or two service users currently in treatment for alcohol and occasionally drug dependence. The service user gives their testimony, speaking openly and honestly to the group and answering any questions they may have. Whilst similar to the previous testimony from a doctor the small groups encourage greater student participation and questioning. Students are encouraged to reflect upon their own drug and alcohol use by the facilitator.

Fig 1. Alcohol as a vertical theme.

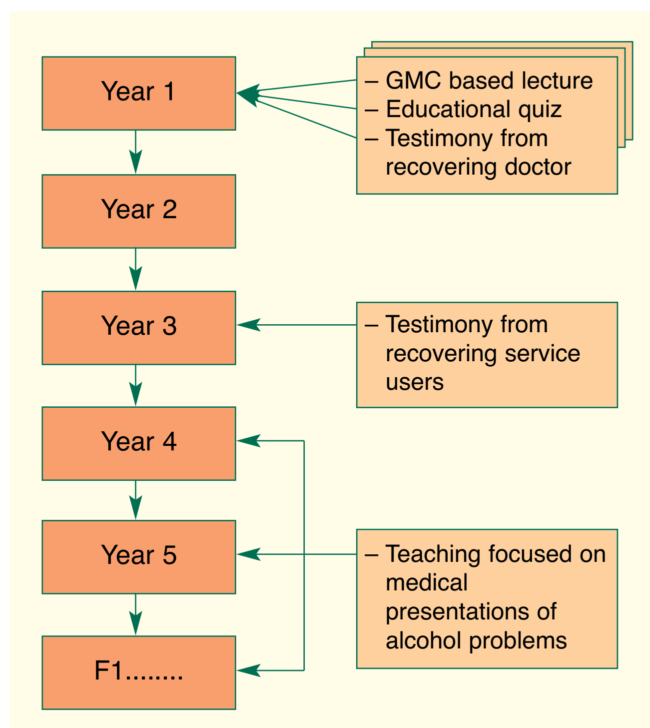

Fig 1. Alcohol as a vertical theme.

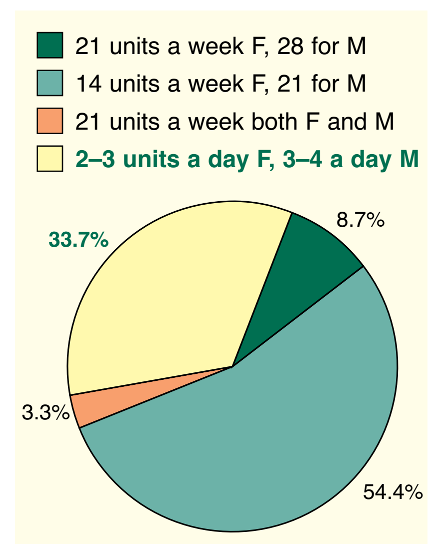

Fig 2. Safe drinking limits and student responses (M=male, F=female).

Results from educational quiz

Of the 235 students who were enrolled into the first year of medical school, 186 were present for the educational quiz. Of those responding, 101 (57%) were female and 77 (43%) male.

Alcohol knowledge. Students were asked what the current guidelines on safe drinking are. A minority (33.7%) were able to identify the current guidelines but most students (54.4%) opted for the previous guidelines of weekly amounts (Fig 2). A greater proportion of students (45.4%) were able to identify what a binge of alcohol is as defined by current guidelines (eight or more units for men and six or more units for women on at least one day in the week, Office for National Statistics).

Students were asked to calculate how many units a person had drunk on a night out. The drinks were shown pictorially on a screen with the volume of liquid and the percentage of alcohol given. The correct total alcohol drunk (20 units) was identified by 31.2% of students (Fig 3).

3 x 250ml glasses of 12% wine + 2 x pints of 5% lager + 5 x 40% shots	=	3 x 3 units + 2 x 3 units + 5 x 1 units	=	Responses	
				15 units	17.0%
				18 units	26.9%
				20 units	**31.3%**
				22 units	24.7%

Fig 3. Medical student responses to calculating units task.

Medical students' personal responses. The students were asked to respond to questions about their own lifetime alcohol and drug use and their use in the previous month. Each person was allowed to respond positively to each stem. 15% described themselves as having never used alcohol or the illicit drugs indicated (Fig 4). All those who had ever used alcohol (84%) had consumed it recently. Lifetime use of cannabis was 30% but only 9% were recent users. Cocaine and psilocybin (magic mushrooms) were the next most used commonly substances.

The students were asked if they had kept to safe drinking levels as recommended by the current government guidelines in the preceding week. Only 33% of all students had kept within the current guidelines (Fig 5). Of those who admitted to using alcohol (n=157), 125 (80%) had drunk in excess of the guidelines within the previous week. 62 students, 33% of the total, admitted they had binged on alcohol, according to current definitions, the night before the lecture.

The lecture posed questions to the students such as whether they had driven when they believed they were over the legal limit, how alcohol affects personal health, why the students used alcohol themselves, and when they would be concerned by a friend's drinking. These data and further questions are not presented here.

Discussion

We report on an intervention and data obtained by students as they embark on their medical careers. Few students could correctly identify the current guidelines on safe drinking which have now been in place since 1995. However the main aim of the lecture was to encourage the students to consider their own drug and alcohol use and the responsibilities of embarking on a career in medicine. Using an interactive format appeared to generate much discussion and reflection although we cannot quantify this at present.

Several previous studies report on drug and alcohol use in British medical students. A study of 3,075 second year medical students reporting in 1996 found 11% to be non-drinkers.[2] Encouragingly our cohort has a higher level of non-drinkers (15%); however, this could be due to the changing cultural and ethnic mix of students

Drug use in lifetime	
Alcohol	84%
Cannabis	29%
Cocaine	6%
Psilocybin	6%
Ecstasy	5%
Amphetamines	2%
None	15%

Drug use in the past month	
Alcohol	84%
Cannabis	9%
Cocaine	1%
Psilocybin	2%
Ecstasy	2%
Amphetamines	1%
None	15%

Fig 4. Medical students' drug and alcohol use.

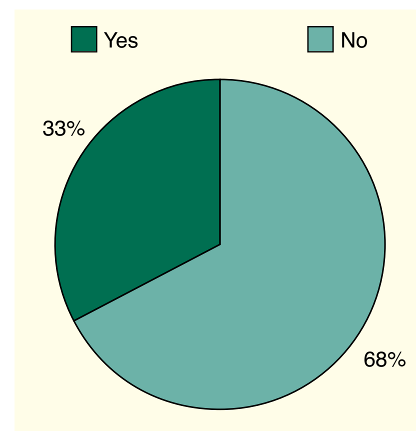

Fig 5. Percentage of all students who had kept within the current alcohol consumption guidelines in the last week.

over the last 10 years. In the previous sample 49% of drinkers exceeded the then 'sensible' drinking levels of 14 units a week for women and 21 units for men, whereas in our sample 80% of drinkers admitted exceeding the new guidelines. The lecture took place in the week after 'freshers week' so unfortunately this could reflect the prominence of alcohol as part of student initiation into the university lifestyle.

As with the general UK population cannabis is the most used illicit drug in surveys of medical students.[2–4] In our sample 29% had used cannabis ever and 9% had used it in the preceding month. This is much less than second year medical students in 1996 where 60% of men and 55% of women had ever used cannabis and 20% reported at least weekly use.[2] 45% of first-year medical students in Newcastle sampled in 1998 had ever used cannabis, with 12% reporting at least monthly use.[3] Previous studies reported an increase in experimentation with illicit drugs as medical students progress through medical school and into working life as doctors, although a time effect should be expected.[4]

Previous studies have shown that students are poor at assessing units of alcohol in alcoholic drinks with only 0.2% of a sample of 979 medical, nursing, and psychology students being able to correctly identify the units of alcohol in all 10 alcoholic

drinks presented.[5] In our data only 31% of students were able to correctly identify the total amount in units drunk for three different alcoholic beverages. This demonstrates a worrying gap in students' knowledge about safe drinking.

As tomorrow's doctors, medical students will soon be the role models and opinion leaders for the public. Students' drinking behaviour will influence their own experience of treating service users with drug and alcohol dependencies. Reduction in cigarette smoking amongst doctors is a good example of how doctors can be positive role models for society. Patients could no longer use the smoking habits of their doctor as an argument to continue their own smoking and the same initiative could be applied to alcohol consumption. We plan to continue this initiative in first year medical students arriving at the University of Bristol and we will continue to monitor levels of drug and alcohol use as these students progress through medical school.

References

1 Department of Health. *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients.* www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137232

2 Webb E, Ashton C H, Kelly P, Kamali F. Alcohol and drug use in UK university students. *Lancet* 1996:348;922–5.

3 Newbury-Birch D, White M, Kamali F. Factors influencing alcohol and illicit drug use amongst medical students. *Drug Alcohol Depend* 2000:59;125–30.

4 Newbury-Birch D, Walshaw D, Kamali F. Drink and drugs: from medical students to doctors. *Drug Alcohol Depend* 2001:64;265–70

5 Searle E, Nausheen B, Sinclair J. Estimating the alcohol content of commonly consumed beverages: knowing the 'standard drink'. *J Psychopharmacol* 2009:23(6)Suppl;A75.

Alcohol, sexual behaviour and sexually transmitted infections

S Sundaram, specialist registrar GUM, S Samraj, consultant physician GUM, and R Patel, senior lecturer/consultant physician GUM

Department of Genitourinary Medicine, Royal South Hants Hospital, Southampton

Introduction

Alcohol misuse is an important risk factor for unsafe sexual practices and is implicated in the rise and spread of sexually transmitted infections (STIs). The link between excessive alcohol consumption and sexual risk may seem self-evident but has been difficult to demonstrate. A systematic review of world literature by Cook *et al* found only 11 studies that included specific measures of problem drinking, of which eight found a significant association between excess alcohol use and at least one sexually transmitted infection.[1]

Patients of sexual health clinics have been identified as having higher levels of risky alcohol consumption than those in other healthcare settings and the general population. Studies conducted in sexual health clinics have shown that the prevalence of heavy drinking ranges from approximately 30% to 65%. A recent study of 520 genitourinary medicine (GUM) clinic attendees in the south of England showed that 86% exceeded the UK government 'binge drinking' limit of 6 units. A total of 77% of patients had been drinking before sex with a new partner and of these 65% were usually or occasionally very drunk. 29% of patients diagnosed with a bacterial sexually transmitted infection reported binge drinking.[2]

The impact of alcohol on sexual behaviour is multi-factorial. It is well recognised that binge drinking disinhibits the cognitive abilities necessary for engagement in safe sex. Alcohol use can increase the risks of having unprotected sex, particularly in adolescents and during first sexual intercourse. Individuals with higher or problematic alcohol consumption have more sexual partners, and are more likely to have had a sexually transmitted infection. Global association studies and surveys suggest that the use and abuse of alcohol is a good predictor of risky sexual behaviour.[3]

A prospective community study on a sample of 208 women aged 16–24 showed that the three main variables associated with an increased risk of chlamydia in this group were:

- age at which they first drank alcohol
- number of lifetime partners
- binge-drinking.[4]

In addition to fuelling a sexual health crisis, alcohol use has been associated with increased risk of acquisition and transmission of HIV in multiple studies in subSaharan Africa. This underscores the importance of developing specific strategies to address substance abuse in addition to promoting screening and behavioural interventions in the control of the HIV epidemic.

In a GUM clinic setting, alcohol misuse in patients poses a number of challenges to physicians and other healthcare professionals. In addition to promoting sexual risk taking, alcohol misuse can affect compliance with treatment for sexually transmitted infections. This may result in treatment failure, increased transmission of disease in the population and emergence of resistant organisms.

A prospective study

We investigated the links between patients' drinking habits and compliance with therapy for STIs at the Department of Genitourinary Medicine, Southampton. In a small prospective study, we looked at 274 GUM clinic attendees who required a week's course of antibiotic treatment. A detailed alcohol history was taken at the initial clinic attendance. At the initiation of therapy patients were advised to comply with their medication and abstain from sex during the treatment period. No advice was given to moderate or limit alcohol consumption. Compliance to therapy and behavioural advice was assessed at a routine follow-up visit at which the extent and patterns of drinking during the treatment period were ascertained.

Generally, high levels of compliance with therapy and behavioural advice were reported. A total of 267 (97%)

patients reported compliance with the prescribed treatment, 253 (93%) reported compliance with advice regarding sexual abstinence and 249 (91%) reported compliance with both aspects. Data demonstrated that over the one-week treatment period, around 45% patients drank, with around 9% patients reporting binge drinking. Univariate analysis was carried out on each relevant variable. Where appropriate Pearson χ^2 tests were carried out to compare several demographic, lifestyle, and patient presentation factors and their association with compliance.

Patients who drank over the treatment period had a 42% chance of non-compliance compared to the patient who did not drink. Patients who reported binge drinking over the treatment period had a 79% chance of non-compliance compared to the patient who did not binge drink. The 21 patients who reported sexual contact over the treatment period were further questioned on whether alcohol was a factor in their sexual encounter. Alcohol consumption was reported to be a factor in six cases. Further to this, alcohol had led to three of these patients undertaking risky sexual behaviour.

High alcohol consumption, particularly binge drinking (8 or more units for men and 6 or more units for women on a single day[5]) was found to be the only significant variable associated with non-compliance with behavioural advice ($p<0.001$). Non-significant trends were also found in relation to alcohol use and compliance with medication. In the treatment of a STI, non-compliance to drugs and advice around sexual abstinence both necessitate re-treatment.

The findings of our study showed that sexual health clinic clients represent a high-risk population in terms of excessive alcohol consumption and the health consequences of it; therefore there is value in obtaining an alcohol history in GUM clinic attendees. Clinicians may wish to identify and appropriately refer patients with hazardous drinking habits which may well be associated with their clinic attendance.

A recent paper has shown that simple screening for alcohol misuse and brief on-the-spot intervention in the form of advice on alcohol consumption is a feasible proposition in the GUM clinic and acceptable to the majority of patients.[6] In the current climate, sexual health clinics are suffering as a result of space and time pressures. Nevertheless, integration of alcohol screening and brief advice as a minimum should be considered, given that alcohol is an important risk factor in the spread of STIs and that early intervention is the most appropriate strategy to address this problem.

References

1. Cook RL, Clark DB. Is there an association between alcohol consumption and sexually transmitted diseases? A systematic review. *Sex Transm Dis* 2005;32:156–64.
2. Standerwick K, Davies C, Tucker L, Sheron N. Binge drinking, sexual behaviour and sexually transmitted infections in the UK. *Int J STD AIDS* 2007;18:810–13.
3. Dingle GA, Oei TPS. Is alcohol a cofactor of HIV and AIDS? *Psychol Bull* 1997;122:56–71.
4. McMunn VA, Caan W. Chlamydia infection, alcohol and sexual behaviour in women. *Br J Midwifery* 2007;15:221–4.
5. Office of National Statistics. *Drinking: adults' behaviour and knowledge in 2004*. London: ONS, 2004.
6. Lane J, Proude EM, Conigrave KM, de Boer JP, Haber PS. Nurse-provided screening and brief intervention for risky alcohol consumption by sexual health clinic patients. *Sex Transm Infect* 2008;84:524–7.

MCA AGM and Seminar

At the Royal College of Physicians
26 November 2009, 11.00 am

Coffee available from 10.30am

The fourth annual Max Glatt Memorial Lecture will be given by our president, Professor Sir Michael Marmot, on *Alcohol and the social determinants of health*

Lunch 12.30pm

The post lunch seminar at 1.30 pm will concentrate on alcohol and cancer.

Speakers will include:

Professor Graham Ogden, University of Dundee
The synergy between alcohol and smoking in the development of oral cancer

Dr Gillian Reeves, reader in epidemiology, Cancer Epidemiology Unit, University of Oxford
Alcohol and breast cancer

Dr Stephen Ryder, consultant in hepatology, Queens Health Centre, Nottingham
Alcohol and hepatitis C in the aetiology of primary liver cancer

FOUNDED 1967

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

5 St Andrews Place, London NW1 4LB
Tel: 020 7487 4445 Fax: 020 7935 4479

Email: mca@medicouncilalcol.demon.co.uk

Website: www.m-c-a.org.uk

Registered Charity Number 265242

Alcoholis, the quarterly bulletin for medical and allied professions is published by the Medical Council on Alcohol, in association with the Royal College of Physicians. Views expressed by contributors are not necessarily those of the MCA who, nevertheless, welcome comments from other parties and will publish selected signed correspondence.

This bulletin has been supported by an unrestricted educational grant from Archimedes Pharma UK Ltd.