

General practitioners' and practice nurses' knowledge of how much patients should and do drink

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SUMMARY

Despite evidence linking high levels of alcohol consumption to ill health, the number of people drinking above the 'sensible' limits is increasing. Clinicians in primary care can influence this trend by appropriate screening and advice. To do this they need to know the recommended sensible limits and also be able to translate commonly reported drinking levels into units of alcohol. A postal survey of 499 general practitioners and 343 practice nurses in Cornwall and South West Devon asked responders to calculate the number of units of alcohol contained in six different drinks and also state what they thought were the current sensible levels of consumption. The response rate was 63%. Less than 40% of responders were able to assess the units of alcohol in five out of the six drinks to within 10%. Over 70% of responders were unable to determine the alcohol content of all six drinks to within 30%. Forty-four per cent of responders now recommend an increased safe level of consumption at 28 units per week for men and 21 units per week for women, against the advice of the Royal Colleges and the BMA but in line with the levels suggested by the Government.

Keywords: alcohol drinking; general practitioners; practice nurses.

Introduction

IN 1990, 28% of men and 11% of women in Britain drank more than the 'sensible' limits (21 units per week for men, 14 units per week for women). The Health Strategy target for England calls for a reduction to 18% and 7% respectively by the year 2005.¹ In 1995, the Government's review, *Sensible Drinking*,² was carried out following a parliamentary question in the light of evidence that drinking alcohol might give protection against coronary heart disease.³ Evidence to the review from the Royal Colleges⁴ and the BMA⁵ considered that, despite the reduced coronary heart disease mortality and morbidity in men over 40 years and postmenopausal women who drank one to two units of alcohol a day, there would be no benefit either to the individual or to the population in changing to the recommended sensible limits.

Brief interventions have been shown to reduce consumption by over 20% in the large group of people with raised consumption.⁶ The recommendations in *Better Living — Better Life*⁷ are that an alcohol history should be taken, reviewed at regular intervals, and the history recorded in units. *Sensible Drinking* considered that, in the United Kingdom, the unit of alcohol is sufficiently part of the currency of public health education for it to be used in recommendations. However, it has been suggested that doctors are not always the best judge of the unit value of drinks.^{8,9}

Our aims were to determine the knowledge of general practitioners (GPs) and practice nurses (PNs) regarding current recommended limits and the alcohol content of alcoholic drinks as they might be recorded during a consultation.

Method

In 1999, a postal questionnaire was sent to all Cornish GPs ($n = 305$) and PNs ($n = 198$) and also to 194 GPs and 154 PNs in Plymouth and south-west Devon.

The study was piloted to 50 PNs and 50 GPs in the Torbay area (response rate = 60%) leading to minor changes in design. Non-responders were followed up with a further explanatory letter and questionnaire.

The questionnaire listed six common drinks, detailing the volumes and the alcohol content expressed as percentage alcohol by volume (%abv). Responders were asked to calculate, for each drink, the alcohol content in units (Table 1) and to state the current recommended safe drinking levels in units for men and women. They were also asked to state whether the practice had a designated alcohol counsellor and, if so, for how long; their year of qualification; and the length of time they had been working in general practice.

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Table 1. Alcohol content (in units) of six common drinks and responders' accuracy in calculating each value. The units contained in any given drink can be calculated from [volume (ml) x % alcohol by volume (%abv)] divided by 1000.

	Correct value (rounded to nearest unit)	Accuracy of unit assessment (%) to within 10%	Underestimation of unit content (%) by more than 30%	Overestimation of unit content (%) by more than 30%
10 pints of lager (Stella Artois) 5.2% abv	30	40	31	5
10 pints of bitter (Boddington's) 3.8% abv	22	88	6	1
4 bottles of red wine 12% abv (70 cl size)	36	12	53	3
1 bottle of gin 37.5% abv (70 cl size)	26	12	5	27
10 cans of Grolsch premium lager 5% abv (500 ml size)	25	26	11	7
10 cans of Diamond White cider 8.4% abv (440 ml size)	37	33	44	4

HOW THIS FITS IN

What do we know?

There is a clear body of evidence supporting the reduction of alcohol in excess of recommended levels, with national targets specified. It is accepted that alcohol consumption should be assessed and quantified in units.

What does this paper add?

There is a tendency for healthcare professionals to unintentionally underestimate units consumed by not using the formula: units = $\frac{\text{volume (ml)} \times \% \text{abv}}{1000}$.

The paper adds to the case for mandatory unit labelling of alcohol beverages and an education campaign for professionals with clarification of sensible drinking recommendations.



Results

The response rate was 63% for both professions. There was a between-county difference in the presence of alcohol counsellors, with 81% of practices in Cornwall and 7% in Devon having counsellors.

The accuracy with which responders were able to assess the alcohol content of the listed drinks was low. Table 1 shows the correct values and responders' accuracy on each drink.

Eighty-eight per cent of responders assessed the unit content of bitter to an accuracy of within 10%. Less than 40% were able to assess any other of the listed drinks this accurately and 4.2% were able to assess all six different drinks to an accuracy of 10%. Over 70% were unable to determine the alcohol content of all six drinks to within 30%.

There was no significant difference between the ability of doctors and nurses in assessing the unit content or their opinions as to the current sensible drinking levels. GPs and PNs with a counsellor were significantly more able to estimate alcohol ($P < 0.05$) using cross tabulation of scores for numbers accurate to within 30%. There was no correlation of year qualified or time in practice with accuracy.

Safe drinking recommendations were expressed by responders as both daily (11%) and weekly (89%) amounts. Three per cent mentioned alcohol-free days. Fifty per cent recorded the safe drinking level for men as 21 units per week, 44% said 28 units per week, and 4.5% said 35 units per week. For women, 52% recorded the safe drinking level

as 14 units per week, 44% said 21 units per week, and 2% said 28 units per week.

Discussion

Health care professionals involved in screening for alcohol consumption above the recommended levels should be able to accurately assess the unit content of any drink and have a consensus on current sensible drinking recommendations. It would appear that neither is true. The only drink assessed to within 10% accuracy by the majority was bitter (88%) and only 4.2% of responders were able to assess accurately the whole range of drinks. This would suggest that GPs and PNs are either unaware of the formula for calculating unit content of drinks or that it is too time-consuming to use; the result is a potentially dangerous underestimate. The previous health education advice of one pint of bitter = 1 unit, one glass of wine = 1 unit, one measure of spirit = 1 unit, etc. is no longer appropriate as it provides no effective mechanism to assess the ever-increasing range, strength, and volumes of alcoholic beverages. The previous advice was also more appropriate to 'pub' consumption rather than the now large 'take-home' market.

The study could have been improved by addressing the difference between those practices with counsellors and those without — the decision was deliberate to keep the study simple.

The 1996 General Household Survey¹⁰ revealed a steady increase in the percentage of females drinking above 14 units per week, from 11% to 14%. If National Health Strategy targets are to be met by the year 2005 then a simple measure would be for the British Government to follow the Australian example and legislate for 'unit labelling' on all alcoholic drinks. Work prior to the Australian legislation showed that when consumers are presented with containers labelled with %abv or 'standard drinks' (units), they consistently underestimate the alcohol content of the drinks labelled with %abv compared with those that were unit labelled.¹¹

On 28 July 1999, six major drinks companies followed the example of the Asda, Co-op, and Tesco supermarket chains in labelling their products with alcohol 'unit content' — this covers approximately 150 brands and 50% of the take-home market.

The survey results suggested confusion as to the current 'sensible' drinking recommendations. Only 11% chose to express drinking guidelines as a daily benchmark (to avoid

binge drinking) as in the 1995 *Sensible Drinking* recommendations. It would appear that 44% of responders are now advising an increased recommended sensible limit of 28 units per week for males and 21 units per week for females. Fifty per cent are recommending levels of 21 units per week for males and 14 units per week for females. It may be that those recommending the lower levels do so according to the Royal Colleges' and the BMA's advice, lending support to previous comments that confusion and uncertainty exists as to the sensible limits. If this confusion persists then achieving the National Health Strategy and WHO¹² targets is likely to be difficult, if not impossible.

Saving Lives: Our Healthier Nation was published on 6 July 1999. It indicated an intention to publish an up-to-date alcohol strategy after consultation early in the year 2000. The Government should take the opportunity to legislate for bold 'unit labelling' on the front of alcoholic drink containers and clarify what in fact are the recommended sensible drinking guidelines.

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