

# Early at-risk alcohol intake

## *Definitions and physicians' role in modifying behaviour*

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### ABSTRACT

**OBJECTIVE** To learn from a sample of general practitioners and their patients how they define early at-risk alcohol intake and what they perceive the physician's role in helping patients with early at-risk alcohol intake to be.

**DESIGN** Survey questionnaire.

**SETTING** Family practices in Kamloops, BC, and the Department of Family Practice at Vancouver General Hospital.

**PARTICIPANTS** Thirty-one family physicians and 860 of their patients.

**MAIN OUTCOME MEASURES** Demographic variables and definitions of alcohol intake, opinions on appropriate interventions for physicians.

**RESULTS** Patients' median estimate for the limit of early, at-risk drinking for a 75-kg man was two drinks per day and 11 drinks per week; doctors' estimate was 1.5 drinks per day and nine drinks per week. For a 55-kg woman, patients set risk to begin at 1.5 drinks per day and nine drinks per week; doctors set it at 1.2 per day and eight per week. However, patients thought there should be 4.3 alcohol-free days each week and doctors thought 3.5, both answers inconsistent with the daily and weekly limits set. Most (85%) patients and 97% of doctors think doctors should ask about drinking behaviour; yet only 42% of these patients recalled ever being asked how much they drank.

**CONCLUSION** Both physicians and patients have stringent definitions of early at-risk drinking and believe physicians should intervene. Physicians appear to be intervening less often than expected.

### RÉSUMÉ

**OBJECTIF** À partir d'un échantillon d'omnipraticiens et de leurs patients, connaître leur définition des premiers signes d'une consommation d'alcool à risque et leur perception du rôle du médecin de famille pour aider les patients qui présentent des signes précoces de consommation à risque.

**CONCEPTION** Enquête par questionnaire.

**CONTEXTE** Les pratiques familiales de Kamloops, C.-B. et le département de pratique générale du Vancouver General Hospital.

**PARTICIPANTS** Trente-et-un médecins de famille et 860 de leurs patients.

**PRINCIPALES MESURES DES RÉSULTATS** Variables démographiques et définition de la consommation d'alcool ainsi que les opinions sur les interventions médicales appropriées.

**RÉSULTATS** L'estimation médiane des patients pour la limite des signes précoces d'une consommation à risque pour un homme de 75 kg était de deux consommations par jour et de 11 consommations par semaine ; les médecins, quant à eux, ont estimé que cette limite était de 1,5 consommations par jour et de neuf consommations par semaine. Pour une femme de 55 kg, les patients ont estimé que le risque débutait à 1,5 consommations par jour et à neuf par semaine ; quant aux médecins, ils l'ont estimé à 1,2 consommations par jour et à huit par semaine. Par ailleurs, les patients étaient d'avis que chaque semaine devait comporter 4,3 jours d'abstinence alors que les médecins ont rapporté 3,5 ; ces deux réponses sont incohérentes avec les limites quotidiennes et hebdomadaires établies. La plupart des patients (85 %) et 97 % des médecins étaient d'avis que le questionnaire du médecin devrait inclure les habitudes de consommation ; seulement 42 % des patients se souvenaient avoir déjà été questionnés sur leur consommation.

**CONCLUSIONS** Les médecins et les patients ont une définition rigoureuse des premiers signes d'une consommation à risque et ils sont d'avis que les médecins devraient intervenir. Les médecins semblent intervenir moins souvent qu'on l'aurait espéré.

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## RESEARCH

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### Early at-risk alcohol intake

**T**he purpose of this study was to learn from general practitioners and their patients how they define early at-risk alcohol intake and what they perceive the physician's role in helping patients in this area to be. We define early at-risk drinking as:

a pattern of drinking alcoholic beverages that could, in time, lead to and increase the chances of alcohol-related disease, accidents, or disturbed personal relationships at home or at work, but that does not at the moment fit the definitions of alcoholism or problem drinking.

Early at-risk alcohol intake is a risk factor for alcohol dependence, for problem drinking, and for conditions (accidents, illnesses, and psychosocial disturbances) that might be precipitated by alcohol.

#### Where risk is thought to begin

At an international symposium on moderate drinking and health held in 1993, the lack of precision and concurrence in the literature of definitions of risk was recognized.<sup>1</sup> Skinner<sup>2</sup> noted that the proportion of people who met formal criteria for alcohol abuse (6%; 13.5% ever in lifetime) was a small fraction of the 43% of men and 21% of women who reported having had alcohol problems during the previous 3 years.

A study of how college students rated vignettes of drinking patterns<sup>3</sup> found that the two strongest determinants of a "serious" rating were frequency and amount of drink, not consequences or help sought. Rush et al<sup>4</sup> contrasted the safe upper limits set by British physicians with those set by Canadians. Canadian GPs suggested a safe upper limit for men of 6.4 drinks per week and for women of 5.6 drinks per week; British GPs set the safe upper limit for men at 10.5 drinks per week and for women at 7.9 drinks per week (figures adjusted for the UK drink unit being 0.59 of a Canadian drink unit).

In 1985, British general practice patients were asked to state a reasonable or sensible limit for daily drinking (asked separately for beer, wine, and spirits). Answers varied according to respondents' home region, sex, and consumption category and to which alcoholic beverage was addressed.<sup>5</sup> Heavy-drinking men set the safe daily limit for men for beer at 7 (UK) units; light-drinking men set it at 4 units. Corresponding figures for spirits were 3.5 units and 2 units. Levels set for women's consumption were about 75% of men's.

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Rush et al pointed to two barriers to early intervention by GPs: boundaries between safe (social) drinking, problem drinking, and alcoholism are hard to set; and many people believe that moderate drinking protects health.<sup>4</sup> They proposed five and four categories of alcohol consumption: no risk, low risk, hazardous, harmful, and dependent; and no risk, low risk, high risk, dependent. To date, no study has distinguished future risk from present risk, though guidelines on individual limits were put forward at the 1993 symposium.<sup>1</sup>

#### Physician's role

The Canadian Task Force on the Periodic Health Examination<sup>6</sup> gave early detection of problem drinking and counseling a "B" recommendation, based on Class I evidence. They estimated the prevalence of problem drinking at 15% to 25%. Screening techniques included the direct question, "Have you ever had a drinking problem?"; the Michigan Alcohol Screening Test or the CAGE questionnaire; liver-enzyme testing; and testing blood for macrocythemia. The suggested maneuver comprised identifying the problem, advising patients to reduce consumption, providing follow-up care at regular intervals, and giving feedback to patients. Rush et al,<sup>7</sup> in their extensive review of the literature on alcohol and GP intervention, found several studies that indicated physicians thought they had a legitimate role but felt they were not well prepared to counsel patients. Only 21% thought it rewarding to work with problem drinkers, and only 3% felt very successful in helping these patients.

## METHOD

#### Instrument design

Drafts of the patient questionnaire and physician interview form were presented to the British Columbia Medical Association's Committee on Alcohol and Other Drugs, to the University of British Columbia's (UBC) Ethical Review Committee, and to several alcohol researchers in the Vancouver area. The anonymous, self-administered questionnaire sought basic identifying information; defined early, at-risk, no risk, and problem drinking and alcoholism; asked respondents to estimate daily and weekly amounts of alcohol that would put a 75-kg man and a 55-kg woman in the early at-risk category and the number of days per week people should not drink in order to avoid risk; asked when people should completely avoid alcohol; asked what doctors should

do about early at-risk drinking; asked patients whether their doctors had ever done any of these things; and asked about respondents' patterns of drinking, including when they avoid drinking.

Pilot questionnaires were given to clinical faculty and residents in UBC's Department of Family Practice; revisions and wording changes were made in response to their comments. To encourage a high response rate, the questionnaire was designed to require less than 10 minutes to complete. The reading level of the questionnaire was assessed at Flesch Grade Level 8.7 and Flesch-Kincaid 7.3, both of which fall into the range of standard writing. In pilot testing the interview questions for physicians, it became clear that the best way to be consistent would be to ask physicians to complete the same questionnaire as patients. This also enabled physicians to give final clearance on the questionnaire about to be handed to their patients. After they completed the questionnaire, physicians took part in a structured interview that assessed their clinical training and practice in regard to alcohol problems.

### Sample

The initial plan was to sample from various regions of the province, but for logistical reasons we had to restrict our sample for this initial study to five family physicians from Kamloops, chosen at random from 69 active physicians, and 36 family physicians, chosen randomly from the 82 active staff members of Vancouver General Hospital's Department of Family Practice. Inclusion criteria were that physicians bill more than \$150 000 annually to the medical services commission; be in active urban practice, and have patients who can read English. All five Kamloops physicians and 26 of the 36 Vancouver physicians participated for an overall response rate of 76%. The 10 nonresponding physicians had mean incomes \$25 000 higher than responders. Physicians were contacted by telephone to schedule the face-to-face interviews. Patient questionnaires were left with office staff, with verbal and printed instructions on their use. A \$50 stipend was sent to each participating practice to thank physicians and office staff for their time and effort.

The number of patients per GP was set at 30 so that the proportion of patient response for each practice could be estimated. A systematic sample from each practice would have required stationing field staff in each practice and documenting all patients seen, which was considered neither feasible nor

**Table 1. Demographics of patient sample (n = 860)**

CHARACTERISTIC	N (%)
<b>Age</b>	
• 19-34	313 (36.4)
• 35-49	299 (34.8)
• 50-64	167 (19.4)
• 65-69	64 (7.4)
• 70	17 (2.0)
<b>Sex</b>	
• Male	341 (39.6)
• Female	491 (57.1)
• Unknown	28 (3.3)
<b>Education</b>	
• Elementary	26 (3.0)
• Some high school	113 (13.1)
• High school graduate	170 (19.8)
• Technical training	86 (10.0)
• Some college	140 (16.3)
• College graduate	189 (22.0)
<b>Occupation</b>	
• Management, professional	206 (24.0)
• Clerical, technical, service	262 (30.5)
• Trades, labourer	74 (8.6)
• Student	45 (5.2)
• Retired	76 (8.8)
• Homemaker	82 (9.5)
• Other	79 (9.2)
<b>Visits to this doctor</b>	
• First visit	32 (3.7)
• 2-4	97 (11.3)
• 5 or more	573 (66.6)
• Unknown	158 (18.4)
<b>No. of years seeing this doctor</b>	
• 1	75 (8.7)
• 2-4	141 (16.4)
• 5	496 (57.7)
• Unknown	148 (17.2)

essential. Office staff were asked to give questionnaires to 30 consecutive adult patients (between 19 and 64 years old) and to mail in completed forms. Most forms were mailed within 3 weeks. Some office staff were reluctant to distribute the questionnaires; some patients carried their questionnaires home. Of the 31 practices, 24 returned 28 to 31 completed questionnaires; the remaining seven returned 15 to 27 for an overall response rate of 92.2%.

## RESEARCH

### Early at-risk alcohol intake

**Table 2. Patients' and doctors' estimates of where risk begins**

RISK	PATIENTS	DOCTORS
No. of drinks per day for a 75-kg man		
• No. responding	751	28
• 25th percentile	1.2	1.1
• 50th percentile	1.9	1.5
• 75th percentile	2.8	1.8
No. of drinks per week for a 75-kg man		
• No. responding	728	28
• 25th percentile	6.9	5.5
• 50th percentile	11.3	9.0
• 75th percentile	18.3	13.3
No. of drinks per day for a 55-kg woman		
• No. responding	745	28
• 25th percentile	0.7	0.6
• 50th percentile	1.4	1.2
• 75th percentile	2.0	1.7
No. of drinks per week for a 55-kg woman		
• No. responding	718	29
• 25th percentile	5.5	4.3
• 50th percentile	9.2	8.0
• 75th percentile	13.8	12.5
No. of alcohol-free days per week		
• No. responding	775	29
• 25th percentile	3.0	0.9
• 50th percentile	4.3	3.5
• 75th percentile	5.3	4.4

### Measures

For defining judgments, when we needed a quantitative measure, we chose the 50th percentile (midpoint of the population's judgment) as the best summary value. The 50th percentile omits the extremes at either end, those who would prohibit alcohol at one end and those with very liberal views on alcohol intake at the other. The 25th, 75th, and higher percentiles are presented to give a sense of the overall distribution of responses.

## RESULTS

### Patient population

**Table 1** describes respondents. Women outnumbered men almost 3:2; 70% of respondents were between 19 and 49 years old. Education level was high compared with respondents to the Canada

Health Promotion Survey of 1990, 34% of whom were at an elementary school level and 15% at a university level. Occupational categories were broadly distributed with no striking variation from national survey data. The most prevalent ethnic backgrounds reported were British and Canadian (54%).

### Patient-doctor relationships

These patients had stable relationships with their physicians. Only 9% had seen these doctors for less than 1 year; 58% had seen these doctors for 5 years or more. Only 9% of patients reported fewer than three previous visits to these doctors.

### Definition of early at-risk drinking

How many drinks per day and per week would put a 75-kg man or a 55-kg woman in the early at-risk category? **Table 2** shows patients' and doctors' responses. Doctors consistently set lower limits than patients. When patients and doctors were asked how many days per week people should not drink, responses were arithmetically inconsistent with the daily and weekly limits they had set in previous responses. Only 10% of patients stated that daily drinking was acceptable, compared with 21% of doctors.

When asked to specify situations in which people should completely avoid alcohol (**Table 3**), the unprompted responses of patients and their doctors were similar. Patients emphasized pregnancy and caring for children, while physicians emphasized being at work or school, psychological reasons, at-risk drinking, interfering with life, and sports and exercise.

### Doctor's role regarding early at-risk drinking

Doctors should ask how much patients drink and ask about drinking behaviour say 85% of patients and 97% of doctors (5% of patients and no doctors disagreed). Likewise, 82% to 92% of patients and 90% to 93% of doctors said that, if doctors think patients are drinking too much, even though they are neither alcoholics nor problem drinkers, they should advise patients to cut down, offer counseling, and give follow-up appointments. Most (82%) patients and 77% of doctors thought referral to groups was appropriate. Thus, there is substantial consensus on physicians playing an active role in early at-risk drinking.

Despite strong agreement on intervention, patients reported little actual physician intervention: only 42% of patients recalled ever being asked how much they drank; 9% had ever been told by their doctors to cut down or quit; 6% had ever received counseling about

drinking from their doctors; and 3% had ever been referred to a program for cutting down or quitting.

**Clinical management**

Diagnostic categories used by these GPs included alcoholic (55%), problem drinker (48%), and at-risk alcohol intake or potential risk (6%). One doctor noted whether patients had alcohol-related conditions; 32% categorized patients by the amount consumed per day or per week. Doctors claimed to ask regularly about alcohol consumption with each new patient (95%), during physical examination (86%), during family problems (82%), and when patients are depressed (81%). Few asked regularly about alcohol intake when patients had motor vehicle accidents (24%) or job injuries (6%).

Only 23% of these doctors used the CAGE screening questions regularly, and none used the Michigan Alcohol Screening Test or the AUDIT screening test. Some doctors used laboratory tests to look for alcohol dependency: hemoglobin (35%), mean corpuscular volume (48%), liver enzymes (53%), and  $\gamma$ -glutamyltransferase (61%). The average time these doctors felt they could take to assess the alcohol intake of a 25-year-old patient during an initial complete physical examination was 3 to 4 minutes. These doctors estimated that people with minimal at-risk drinking will spontaneously reduce their drinking between 0 and 25%, with the median being 8% to 10%.

**DISCUSSION**

These patients and physicians thought physicians should help patients to limit alcohol consumption. This study also shows that GPs and their patients will answer questions about early at-risk drinking; such research is feasible. Although the results of this study need to be replicated in a broader sample of physicians and patients, the long-term relationships between doctors and patients in this study indicate a favourable environment for encouraging and supporting habit change.

In defining early at-risk drinking, patients and doctors are remarkably consistent. But patients and physicians set, indirectly, stricter limits in response to the question of how many days per week people should not drink at all. This raises several issues. Was this inconsistency a function of the way the questions were asked, switching from number of drinks allowed (positive) to number of days a person should not drink (negative)? How do people actually

**Table 3. Situations in which people should completely avoid alcohol**

SITUATION*	IDENTIFIED BY PATIENTS (%)	IDENTIFIED BY DOCTORS (%)
Driving	55	58
Pregnancy	47	26
Taking medication	47	45
Medical condition	32	42
At work or school	25	39
At-risk drinker	16	32
Psychological reasons	14	23
Caring for children	9	3
Interferes with life	7	13
Non-drinker	4	0
Exercise, sports	4	16

*\*Other situations mentioned by patients included thinking, daytime, too young or too old, diet, social setting, with alcoholics, and flying. Other situations mentioned by doctors included thinking and daytime.*

control their intake? Do they think in terms of number of drinks per setting or per day or per week? Do they follow their friends' behaviour? Do they respond to bodily cues? Are they giving the answer they think is expected?

According to patients' reports, although both doctors and patients agree that doctors should be asking about drinking and intervening if they see risk, the doctors do not seem to be doing it. More than half the patients (58%) did not recall being asked by the doctor how much they drank. Without identifying those at risk, there is no way to intervene. If 30% of adults have ever been in the alcohol-dependent or problem drinking category, 9% is too few to have been advised to cut down or quit drinking, 6% too few counseled, and 3% too few referred.

Results of this study indicate that these doctors are reaching about one third of patients at risk. However, it is possible that doctors are deciding whom to ask about drinking based on their likely risk status and readiness to change and the knowledge gleaned from their long-term relationships with their patients. Moreover, patients might not recall questions, even though they actually were asked. ➤

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**Indications:** Infections caused by susceptible  $\beta$ -lactamase-producing strains of designated bacteria: upper respiratory tract, skin and soft tissue infections due to *S. aureus*; lower respiratory tract infections due to *H. influenzae*, *K. pneumoniae*, *S. aureus* or *Moraxella* (Branhamella) catarrhalis; otitis media due to *H. influenzae* or *Moraxella* (Branhamella) catarrhalis; urinary tract infections due to *E. coli*, *P. mirabilis* or *Klebsiella* species and sinusitis due to *H. influenzae* or *Moraxella* (Branhamella) catarrhalis. **Contraindications:** History of hypersensitivity to the penicillins, clavams or cephalosporins; history of Clavulin-associated jaundice/hepatic dysfunction; infectious mononucleosis suspected or confirmed. **Warnings:** Before initiating therapy, careful inquiry should be made concerning previous hypersensitivity reactions to penicillin, clavams, cephalosporins or other allergens, as serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. If an allergic reaction occurs, discontinue Clavulin and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, i.v. steroids and airway management, including intubation, should also be used as indicated. Use with caution in patients with evidence of hepatic dysfunction. Hepatic toxicity associated with the use of Clavulin is usually reversible. On rare occasions, deaths have been reported (less than 1 death reported per estimated 4 million prescriptions worldwide). These have generally been cases associated with serious underlying diseases or concomitant medications. **Precautions:** Periodic assessment of renal, hepatic and hematopoietic function should be made during prolonged therapy. Clavulin is excreted mostly by the kidney. Reduce the dose or extend the dose interval for patients with renal dysfunction in proportion to the degree of loss of renal function. The possibility of superinfection (usually involving *Aerobacter*, *Pseudomonas* or *Candida*) should be kept in mind. If it occurs discontinue Clavulin and institute appropriate therapy. The occurrence of a morbilliform rash following the use of ampicillin in patients with infectious mononucleosis is well documented. This reaction has also been reported following the use of amoxicillin. A similar reaction would be expected with Clavulin. As with all medicines, use in pregnancy is not recommended, especially during the first trimester, unless the anticipated benefit justifies the potential risk to the fetus. Penicillins have been shown to be excreted in human breast milk. It is not known whether clavulanic acid is excreted in breast milk. Caution should be exercised if administered to a nursing mother. In common with other broad spectrum antibiotics, Clavulin may reduce the efficacy of oral contraceptives and patients should therefore be advised accordingly. **Adverse Reactions:** Gastrointestinal: Nausea, vomiting, diarrhea, abdominal cramps, flatulence, constipation, anorexia, colic pain, acid stomach, intestinal candidiasis and pseudomembranous colitis. If gastrointestinal reactions are evident, they may be reduced by taking Clavulin at the start of the meal. The incidence of gastrointestinal side effects tends to be proportional to dose and tends to be greater in children than adults. **Hypersensitivity Reactions:** Erythematous maculopapular rash, urticaria, anaphylaxis and pruritis. A morbilliform rash in patients with mononucleosis. Rarely erythema multiforme and Stevens-Johnson syndrome have been reported. Other reactions including angioedema, toxic epidermal necrolysis and exfoliative dermatitis, as in the case of other  $\beta$ -lactam antibiotics, have been seen rarely. **Interstitial nephritis (rarely):** Liver: Transient hepatitis and cholestatic jaundice have been reported rarely. These events have been noted with other penicillins and cephalosporins. Hepatic events associated with Clavulin may be severe, and occur predominantly in adult and elderly patients. Signs and symptoms usually occur during or shortly after treatment, but in some cases may not become apparent until several weeks after treatment has ceased. Hepatic events are usually reversible, however, in extremely rare circumstances, deaths have been reported. These have almost always been cases associated with serious underlying disease or concomitant medications. **Moderate rises in SGOT, alkaline phosphatase and lactic dehydrogenase, and SGPT** have been noted in patients treated with ampicillin class antibiotics. The significance of these findings is unknown. **Hemic and Lymphatic Systems:** As with other  $\beta$ -lactams, anemia, haemolytic anemia, thrombocytopenia, thrombocytopenic purpura, eosinophilia, leukopenia, lymphocytopenia, basophilia, slight increase in platelets, neutropenia and agranulocytosis have been reported rarely during therapy with the penicillins. These reactions are usually reversible on discontinuation of therapy and are believed to be hypersensitivity phenomena. **Prolongation of bleeding time and prothrombin time (rarely):** Other: Vaginitis, headache, bad taste, dizziness, malaise, glossitis, black hairy tongue and stomatitis. **Dosage and Administration:** The absorption of Clavulin is optimized when taken at the start of a meal. **Adults:** For urinary tract, upper respiratory tract, skin and soft tissue infections which are mild to moderate, one Clavulin-250 tablet every 8 hours. For severe infections and lower respiratory tract infections, one Clavulin-500F tablet every 8 hours. **Children:** For urinary tract, upper respiratory tract, skin and soft tissue infections which are mild to moderate, 25 mg/kg/day of Clavulin in equally divided doses every 8 hours. For severe infections, otitis media, sinusitis or lower respiratory tract infections, 50 mg/kg/day of Clavulin in equally divided doses every 8 hours. Children's dosage should not exceed that recommended for adults. Children weighing more than 38 kg should be dosed according to the adult recommendations. Treatment should continue for 48-72 hours beyond the time the patient becomes asymptomatic or bacterial eradication is obtained. At least 10-days' treatment is recommended for infections caused by  $\beta$ -hemolytic streptococci to prevent acute rheumatic fever or glomerulonephritis. **N.B. DO NOT SUBSTITUTE 2 X 250 TABLETS FOR 1 X 500F TABLET. RATIO OF AMOXICILLIN TO CLAVULANIC ACID IS DIFFERENT.** **Supplied:** Clavulin-250 tablets (250 mg amoxicillin, 125 mg clavulanic acid) in bottles of 100; Clavulin 500F tablets (500 mg amoxicillin, 125 mg clavulanic acid) in bottles of 30, 100. Clavulin-125F Oral suspension (125 mg amoxicillin, 31.25 mg clavulanic acid per 5 ml) and Clavulin-250F Oral suspension (250 mg amoxicillin, 62.5 mg clavulanic acid per 5 ml) in bottles of 100, 150 ml. Product monograph available on request.

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Only half of physicians reported using the categories alcoholic and problem drinker, despite the high prevalence of such conditions and the potential effectiveness of physician-based intervention. If many of the more serious alcohol-related problems are being missed, early at-risk drinkers likely are being missed also.

### Conclusion

In the absence of long-term, prospective studies identifying the early patterns of alcohol consumption that lead to future trouble, we have sought patients' and their physicians' definitions of early at-risk drinking. We used patients' and physicians' median responses to define drinking in terms of number of drinks per week, number of drink-free days, and situations in which alcohol should be completely avoided. Patients' and physicians' definitions were similar. Though 90% of respondents thought physicians should ask about drinking, only 42% of these 860 patients reported ever being asked about alcohol intake.

Screening, treating, and preventing alcohol-related problems are not yet integrated into primary care practice. More studies are needed to show whether early at-risk drinking intervention by physicians is effective so that physician education can be directed appropriately. Otherwise, we should emphasize the need for screening for alcoholism and problem drinking, which is supported by evidence. It is not yet appropriate to press physicians to incorporate preventive behaviours that take time if evidence of efficacy is lacking.

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