Teaching Alcoholism to Family Medicine Students

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Alcoholism is a major health problem in the United States, yet it has not received high priority in medical education. Although it affects many patients who attend the offices of family physicians, it frequently remains unrecognized. It is therefore an appropriate topic for a family medicine course and has been integrated into a third year clerkship at the University of Washington.

Students are taught basic diagnostic and management skills by sensitizing them to the magnitude of the problem and addressing some professional attitudinal blocks. History taking skills emphasizing early recognition and intervention are stressed, and the role of community resources in treatment is demonstrated through discussion and site visits.

There are approximately 10 million alcoholics in this country, according to the *Third Special Report to the Congress on Alcohol and Health*.[1] It has been estimated that one half of all traffic fatalities are alcohol related (25,000 deaths annually). The link between alcohol abuse and suicide, homicide, and accidential death is equally alarming.[1]

In a study of 200 medical and surgical inpatients, Moore concluded that 18 percent of male patients and 5.5 percent of female patients were alcoholic.[2] Barchha et al, who studied 329 medical inpatients, identified 27 percent of the men and 6 percent of the women as alcoholics.[3] Studies of other hospital populations at high risk (such as veterans and blacks) have produced figures as high as 69 percent of males and 34 percent of females who are affected by the disease.[4,5] Emergency room visits were examined by Solomon et al, who estimated the problem of alcoholism in patients arriving at New York County Hospital at between 9 percent and 25 percent, depending on the method of assessment.[6] Other studies provide similar figures.[7]

The credibility of the figures mentioned above is weakened by the variety of definitions of alcoholism used and by the different instruments employed in identifying patients as alcoholic. Nonetheless, by any criteria alcoholism constitutes a massive health problem, yet it has been a neglected topic in medical schools. Surveys of medical school curricula in alcoholism and drug abuse indicate an improvement in content over the last decade,[8] but a significant number of schools still teach very little about this subject. Descriptions of successful curricula in the literature are sparse.[9,10]

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Where instruction does occur, it tends to concentrate on the treatment of late medical complications. Through this exposure, medical students learn to deal with the terminal consequences of alcohol abuse but are rarely taught the skills necessary to identify patients at risk or to identify and intervene in early stage alcoholism. In addition, contact with end stage alcoholics fosters an attitude of hopelessness and therapeutic nihilism, reinforcing medical students' negative feelings toward such patients.[11]

To implement teaching of the early recognition and management of alcoholism as a progressive and chronic illness, it was decided to introduce an alcoholism module into a family medicine clerkship. The focus of the module is practical and intended to teach skills useful in managing alcoholism as one of the chronic problems commonly seen in ambulatory family practice. With an estimated 10 million alcoholics in this country, one in every five patients in the family physician's waiting room is either alcoholic or directly affected by a friend or relative who is. A four-week, third year clerkship in family medicine was chosen for the introduction of the subject. This clerkship is conducted at the nine University of Washington affiliated family practice residency programs. It places a heavy emphasis on a didactic core of family medicine, and involves the students in numerous site visits to community health care agencies. In order to maintain a balanced approach to the whole field of family medicine, it was decided to devote an afternoon seminar session and a small number of site visits to the teaching of alcoholism. It was felt that a greater emphasis would not be appropriate within the framework of a four-week course.

As a first step, an advisory committee was formed to define module objectives, review curricular materials, and suggest appropriate clinical experiences. The contribution of the advisory committee has been crucial to the success of this module. Representatives from a number of alcoholism treatment centers, a recovering alcoholic physician, residents, and students were invited to join the advisory committee and have provided an invaluable source of expertise and constructive criticism. The solicitation of advice from the alcoholism treatment community, traditionally so suspicious of medical schools, has probably been the single most helpful step in designing and maintaining an effective program.

The Program

The module objectives represent a radical departure from the usual medical school approach to alcoholism, since they are directed at the following elements: (1) risk identification, (2) early recognition, (3) confrontation and intervention as appropriate for primary care physicians, (4) consultation and referral to community treatment resources, (5) provision of family support, and (6) awareness of physicians as belonging to a profession at high risk for alcoholism. The learning materials and activities used are designed to fulfill these objectives.

The alcoholism module consists of the following three components: a three-hour seminar, two site visits to a treatment center, and a visit to an Alcoholics Anonymous meeting.

The Seminar

This occurs early in the clerkship in order to provide the students with the background needed for the clinical experience and site visits to follow. The first portion of the seminar is designed to increase students' awareness of the magnitude of the problem and to motivate them to identify the problem at an early stage. It begins with the presentation of slides dealing with the prevalence of alcoholism based on statistics culled from the literature, in particular the Third Special Report to Congress. This is followed by a brief discussion of societal and ethnic attitudes toward alcohol and alcoholism and the way in which a physician's background, upbringing, and personal experiences with alcohol may influence therapeutic effectiveness. An important underlying theme of this discussion concerns the students' own drinking habits and the propensity for physicians and other health care professionals to develop drinking problems.

The effects of alcoholism on a family unit are illustrated through the use of the film, *Soft Is the Heart of a Child,** which is an ideal length for teaching (approximately 25 minutes), and demonstrates some of the typical behaviors that occur in a family in which one of the adults has a serious drinking problem. The film provides a focus for discussion of family dynamics and illustrates the typical responses of children to family stress in

*Produced by Gerald Rogers and distributed by Project Cork, a Program of the Kroc Foundation, San Diego, California, 1978

such a situation: withdrawal, acting out, or the assumption of the parent role. Discussion of these issues provides a natural lead into the diagnosis of alcoholism in outpatient practice.

History taking skills are illustrated as the fundamental diagnostic tool, using a videotape made specifically for this course. The technique of taking a history of alcohol consumption from a normal patient and an alcoholic are contrasted on the tape, and a history taking technique emphasizing the negative consequences of drinking is delineated. The videotape finishes with an example of a contract as a mechanism for breaking down patient denial. If time permits, the students then role play history taking from seminar faculty who have rehearsed brief vignettes demonstrating the variety of presentations of the alcoholic in the office.

Following an examination of history taking skills and some simple methods by which denial can be broken down, the technique of "intervention" is illustrated through the use of a segment of the middle reel of *I'll Quit Tommorrow*.* Depicted are a concerned employer, family members, and colleagues at work, all of whom confront the alcoholic with instances in which his behavior has affected them in an attempt to coerce him into treatment. Strategies for family support are also discussed, both when the alcoholic accepts treatment and when he or she does not. Finally, a description of community resources is given. A brief outline of the types of residential and outpatient programs available is presented, and consideration is given to the appropriate choice of a treatment program for a variety of patients.

To supplement the seminar, a handout is included with the course syllabus which provides a summary of information available on the prevalence of the disease, ethnic differences in drinking patterns, social attitudes toward alcohol and alcoholism, and reprints illustrating the influence of physicians' attitudes on therapeutic effectiveness. Also included are an article by Jon Weinberg on interviewing strategies[12] and an information sheet that deals with the typical findings in the history, physical examination, and special investigations in the early, middle, and late stage alcoholic. A comprehensive list of community resources in the Seattle area is also made available, with a brief description of each program and key telephone numbers that a physician might need to coordinate the entry of a patient into the treatment system.

Site Visits

Two site visits to a single alcoholism treatment center are included in the alcoholism module. Although each student may not necessarily be sent to the same site, it is important that the second visit should be to the same treatment center and should occur ten days to two weeks from the first visit in order to give the student an opportunity to observe improvement as patients progress through the program. The selection of a treatment center is important. There are examples of a number of different types of treatment centers in Seattle, ranging from an aversion therapy program to an individual counseling and group therapy program. It was decided initially that students would respond best to the latter, since it most closely follows the model they are familiar with in medical training. They are therefore sent to a counseling program with a heavy emphasis on Alcoholics Anonymous (AA). This arrangement has worked well. Students certainly perceive the value of such a program, and their exposure leads to a much more positive attitude toward treatment. They receive a brief introduction to the program when they arrive on site and then join the patients for a lecture and a group therapy session. They are involved in sit-down rounds, where each patient's progress is discussed, and then meet an assigned patient from whom they take an alcohol history. On their second visit, the schedule is similar, with an opportunity to see the same patient and discuss his or her progress. At some time during one of these two visits, they meet with the medical director who discusses the principles of detoxification.

Students also attend an AA meeting with a recovering alcoholic physician. Since AA is one of the most widely used sobriety maintenance programs in the alcoholism treatment field, it is important for students to understand how AA can be useful to alcoholics. Attending an open meeting with a professional role model who can help translate the students' observations of the AA meeting into the therapeutic dynamics of the program is invaluable in educating students about the potential benefit of using AA as a resource in their own practices.

*Produced by Gerald Rogers and distributed by the Johnson Institute for the Treatment of the Chemical Dependency of Alcoholism, Minneapolis, Minnesota, 1975

Evaluation

The students have greeted the program with enthusiasm. On a five-point scale with a score of 5 as "great value," the alcoholism module received a rating of 4.3 (n=19). The seminar has been a strong point of the program, receiving a rating of 4.5. The treatment center has been rated slightly lower at 4.1. Students have occasionally criticized the visit because of the seemingly unscientific approach of the staff. The counselors have varied backgrounds. Most are recovering alcoholics who have not been trained in typical health science schools. It is not surprising, therefore, that some students regard them with skepticism. It has been important in overcoming their reservations to prepare them for the site visit by explaining the nature and philosophy of the program and the characteristics of the staff.

In the course final examination, students consistently demonstrate an ability to answer accurately multiple choice questions and patient management problems on alcoholism. Furthermore, when a simulated alcoholic patient has been included in the videotaped examination,[13] all students made the diagnosis correctly and, in the opinion of the observers, handled the problem appropriately.

Course faculty have received the program equally well, feeling that an interest in alcoholism treatment has been long overdue in medical schools. Their criticisms, if any, have been related to the limited numbers of students involved and the slowness with which the program has grown. Plans to develop rotations for residents and student electives will respond to many of these criticisms, but continued enthusiasm indicates that the treatment community in this city has an almost insatiable appetite for alcoholism involvement in medical education.

Conclusions

Alcoholism deserves more time in medical education, as it is a pervasive problem amenable to diagnostic and management strategies that students seem to learn readily and apply easily in clinical situations. It is also an excellent example of a chronic disease which has both biomedical and psychosocial components and which affects the whole family unit. It is, therefore, an appropriate topic for a family medicine clerkship. The modular approach described here permits easy integration into an existing curriculum and provides a practical approach to early diagnosis, intervention, and referral rather than an emphasis on late medical complications as has been done traditionally.

The modular approach has also served well as a basis for expansion into other levels of medical education, since components have been used in the medical interviewing course, and the whole structure has formed the foundation for planning a more comprehensive residency curriculum in alcoholism. Materials developed for the module are now being used in presentations to internal medicine and psychiatry residents and in continuing medical education workshops. Thus, the initial time and effort spent in careful planning has been rewarded handsomely. Nevertheless, the authors wish to stress that much needs to be accomplished before medical students and residents in the primary care disciplines will possess the skills to deal adequately with this major health problem.

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