Alcoholism Curriculum Development: An Examination of the Process

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Alcoholism is one of several topics that may be integrated into family medicine clerkship teaching. This article focuses on the process of curriculum development in alcoholism. The process is traced from its beginnings in a third-year clerkship to its integration into the medical school curriculum and other areas of medical education. Strengths and pitfalls in this project are discussed. Enlisting community support and field testing newly developed strategies are emphasized as successful methods. Less successful in this project, though equally important, are faculty development and long-term evaluation. Recommendations for curriculum development in similar projects are made.

Alcoholism has received insufficient attention in the curriculum of medical schools and residency training programs. Most physicians in training are exposed to the end stages of this disease, where treatment of its complications is often palliative at best, and the treatment of the underlying alcoholism itself is rarely successful. It is hardly surprising in this setting that negative attitudes develop toward alcoholic patients.[1-4] For just these reasons, medical school faculty tend to be uninterested in teaching about alcoholism—a sad commentary when alcoholism and alcohol abuse are estimated to consume 13 percent of the national health care budget.[5]

In 1979 the Department of Family Medicine at the University of Washington was awarded a grant from the Kroc Foundation to initiate the development of an alcoholism curriculum in family medicine. This paper describes the process of curriculum development, the strategies used, their success or failure, and some recommendations for others embarking on similar projects. The curriculum development process described may have application to topics such as geriatrics, nutrition, and rehabilitation medicine, which, as does alcoholism, lend themselves best to an integrated and interdisciplinary approach.

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A Curriculum Planning Model

As an initial step in designing a curriculum in this new area, a simple model was developed to assist in planning. The resulting framework, intended to ensure that preliminary efforts were directed in an efficient manner, consisted of the following steps:

1. Determine what students should know about the topic at the completion of medical school.
2. Identify what students are already learning about this topic elsewhere in the curriculum.
3. After arriving at answers to items 1 and 2 and considering logistical and resource limitations, decide what information and skills should be taught to family medicine students.
4. Decide on the appropriate curriculum levels for introducing different aspects of the topic.
5. Select the strategies, materials, and format to be used for teaching.
6. Determine how the program should be evaluated.

After these central issues had been resolved and detailed planning completed, the implementation phase was initiated. The activities that were undertaken to incorporate an alcoholism training program into the undergraduate curriculum are as follows:

1. Conduct field tests of the format and materials, making revisions as required based on evaluation data.
2. Recruit and train faculty to permit expansion to other teaching sites and additional courses.

3. Implement the updated program in new settings.

4. Expand the program to other courses and different levels.

In the real world, events rarely follow such a plan precisely, but the development of this curriculum component was guided to a significant extent by the framework presented above. The process outlined by this model is more fully described in the following sections.

Initial Decisions and Strategies

One of the most important strategies employed during the early stages of the project was the formation of an advisory committee consisting of representatives from a number of alcoholism treatment programs in the Seattle area as well as family medicine faculty members, medical students, and educators. In addition to its essential consultative function, this group of recognized community leaders and practitioners in the field of alcoholism treatment helped to provide the new program with credibility and stature within the treatment community. The group's initial responsibility was to identify skills, knowledge, and attitudes they felt would be useful for new physicians in the diagnosis and management of alcoholism. During later stages, the committee provided valuable recommendations on teaching materials and clinical experiences for the students.

After deliberation it was the consensus of the group that beginning physicians would benefit most from improving their skills in the recognition of alcoholism, particularly in its early stages, and in making appropriate referrals.

A review of existing teaching in alcoholism was conducted with a sample of students, faculty members, and administrators within the medical school. It was found that the current curriculum devoted only a few hours to the topic and emphasized physiology, pharmacology, and medical complications encountered during the late stages of the disease. No training was being provided in those areas that had been identified by the advisory committee as being most critical.

As a result it was determined that the development of a curriculum focused on specialized interviewing skills, recognition of the early indicators of alcoholism, and characteristics of local treatment services would benefit the students and help to fill a gap in their medical education.

The planning of this project was affected by several considerations. Practical constraints on its scope were imposed by the limitation in funds and qualified faculty. As additional grant funds were being sought, expansion at a later date had to be anticipated in the planning process. It was decided to limit the initial thrust of the project to the family medicine predoctoral program and to start with a small pilot project in a setting that permitted experimentation, re-evaluation, and refinement without undue disruption of existing teaching. It was also felt that the project should be placed where it would be highly visible to stimulate faculty interest within family medicine and perhaps eventually in other departments. Later expansion would require the cooperation of the faculty whose support it was hoped to capture at this early stage.

The most appropriate choice for the initial testing and implementation of the alcoholism training program appeared to be the newest of the department's offerings, a third-year clerkship conducted at each of the nine residency programs affiliated with the university. Class size tended to be small, and the curriculum was still evolving. This clerkship provided students with a broad exposure to patients in the residency clinics and to community agencies and resources to which a family physician might refer patients. The clinical experiences were complemented by weekly seminars on a variety of topics. Although the residents were the primary clinical teachers, residency faculty had a high level of involvement in curriculum planning and student evaluation. This clerkship, therefore, seemed to fit the planning requirements well.

The objectives of the clerkship addressed the comprehensive management of problems commonly encountered in family medicine, the interrelationship of biomedical, psychosocial, and socioeconomic factors, the impact of illness on the family, the use of community resources and consultation, and methods of patient education. The management of alcoholism is highly compatible with these objectives, and it became apparent that alcoholism could serve as an effective example for teaching many of the principles of family medicine.[6]

Once the initial location for teaching alcoholism to students had been decided upon, content and format were considered. The pattern set for other

Table 1. Third-Year Basic Clerkship Alcoholism Module

When	Method	Content
Week 1	Three-hour seminar Slides Lecture Films Videotaped interview Small-group discussions Handouts/syllabus Articles	Prevalence Attitudes Early diagnosis Contracts and confrontation Withdrawal Intervention Treatment resources Family support
Week 2	First visit to alcoholism treatment program Participation in group therapy Participation in education program Participation in staff rounds Interview one selected patient beginning treatment and take an alcohol history	Treatment philosophy Group therapy as treatment modality Alcoholism as a disease Rehabilitative process Taking an alcohol history
Week 3	Visit to Alcoholics Anonymous meeting Second visit to alcoholism treatment program Participation in group therapy Participation in staff rounds Interview same patient as in week 2	Dynamics of Alcoholics Anonymous Group therapy as treatment modality Rehabilitative process Progression through treatment program

special topics presented in the clerkship included a seminar, clinic experiences, a visit to a community site, and selected written materials in the syllabus. The same format was followed in developing an alcoholism module. Components included a three-hour seminar, two visits (spaced two weeks apart) to an alcoholism treatment center, and attendance at an Alcoholics Anonymous meeting with a recovering alcoholic physician (Table 1). In the planning and development of this module, the advisory committee served a valuable role in reviewing curriculum material and suggesting clinical experiences.

It was decided that evaluation during the field testing should be aimed primarily at identifying strengths and weaknesses and eliciting suggestions for improvement in the initial offering. This evaluation was accomplished by appropriate questions added to the standard student evaluation questionnaire and a group interview conducted by an educator at the conclusion of the clerkship.

Field Testing the Basic Clerkship Module

The pilot run of the module was then conducted with a group of eight students enrolled in the third-year clerkship at the University of Washington Family Medical Center. Student learning was evaluated through performance in diagnosing a videotaped "hidden alcoholic" simulated patient. At the completion of the clerkship, students and clinical faculty gave very positive evaluations of

the module and suggested no material changes. The students' ability to uncover and appropriately confront alcoholism in the simulated patient supported the practical value of the instruction provided. Since the pilot run, the only major organizational change has been to extend the number of treatment programs for student site visits. This modification resulted from increased student enrollment as well as the desire to provide experience with differing treatment approaches.

Based on the success of the pilot test, recruiting and training additional faculty were begun preparatory to expanding the alcoholism module to other clerkship training sites.

Introduction as a Regular Curricular Component

A faculty development workshop was planned for selected representatives from each of the nine family medicine residency programs at which the clerkship was to be taught. The goals of the workshop were (1) to generate interest in the topic, (2) to identify a nucleus of faculty who would be interested in teaching about alcoholism at their facility, and (3) to familiarize physician faculty with the medical and counseling staff of community treatment programs. The program included several nationally known speakers, a representative from the National Institute on Alcohol Abuse and Alcoholism, and individuals from the local treatment community.

As judged by the evaluations of participants, the workshop was successful in all three of its goals. A small group of faculty and residents from each site were identified as having an interest in teaching the topic and in planning the integration of this new clerkship component.

In retrospect, however, it is apparent that these faculty development efforts would have been more effective in promoting long-term interest in the topic had the following additional steps been taken: (1) a representative from the dean's office should have been invited to provide a demonstration of administrative support, (2) an appropriate clinical experience should have been identified and made available to attendees, (3) a series of follow-up experiences should have been planned to maintain momentum, and (4) the number of faculty invited to participate should have been increased.

Over the balance of the initial academic year, the alcoholism module was incrementally implemented at each of the remaining eight training sites. Seattle area settings were chosen for the initial expansion to facilitate the coordination of any problems. Only minor difficulties were encountered in integrating the new component into the curriculum at each site.

The alcoholism module, which has now been a regular component of the residency-based clerkship for more than three years, remains basically unchanged in content and format with the exception of minor improvements as new information and statistics become available. The module continues to enjoy good evaluations from students even though many issues that were exclusive to the module at its inception, such as interviewing skills, are now being addressed in several other courses and clerkships. It is refreshing to note that students welcome a repetition of some knowledge and skills they see as valuable in preparing them for future medical practice.

In evaluating the effectiveness of the curriculum development process, the uniformly favorable ratings from students at the completion of the clerkship indicated that the material was perceived as cogently presented, pertinent, and timely. To investigate the extent to which students were acquiring new skills and knowledge as a result of their training, however, three multiple-choice items were added to the written portion of the standard clerkship final examination given at all sites, and a videotaped, hidden-alcoholic patient interview was added to the oral portion of the examination. Student performance has been satisfactory over the past three years, indicating that the module has been effective in promoting measurable learning in this new topic area.

Expansion in the Predoctoral Curriculum

Since the initial implementation of the alcoholism module in the third-year clerkship, teaching about alcoholism has been expanded into a number of other areas of the predoctoral curriculum (Table 2). Beginning with the incorporation of alcoholism teaching components into existing family medicine clerkships and preceptorships, material on alcoholism was later added to several required interdisciplinary courses. This process resulted largely through requests from course chairpersons

Table 2. Integration of Alcoholism Curriculum Into Predoctoral Education

When	Where	How	Major Content
1st year	Introduction to Clinical Medicine I (all first-year students)	1-hour seminar Lecture and live patient demonstration	Attitudes History-taking skills
2nd year	Introduction to Clinical Medicine II (all second-year students)	3-hour seminar series Lecture and film Alcoholics Anonymous panel	Prevalence and attitudes Physical findings for diagnosis Family dynamics Treatment resources and Alcoholics Anonymous
	Family Medicine Continuity Clerkship	Two 1-hour seminars Lecture and videotape demonstration	Basics of outpatient management and simple confrontative interview strategies
3rd year	Basic Clerkship in Family Medicine	Module One 3-hour seminar Two one-half-day site visits Alcoholics Anonymous meetings	Prevalence and attitudes History taking Confrontation Intervention Outpatient management of withdrawal Family support Use of community resources
	Human Biology Series (all third-year students)	Three-hour seminar and film	Physician impairment

who had attended presentations by the authors.

The incorporation of material on alcoholism into existing courses was felt to be a more appropriate strategy than the development of free-standing electives because such an incorporation permitted alcoholism to be presented in conjunction with more traditional curriculum components and thus clearly identified the disease as a common medical problem amenable to treatment.

Materials developed for the third-year clerkship provided a useful basis from which to plan and develop components in other areas of the medical school curriculum. It was necessary, however, to modify these materials to match the different levels of student skills and experience and to ensure appropriate overlap with material presented in other courses and clerkships. The aims were to teach all medical students (1) the fundamental skills required to recognize the disease, (2) the characteristics of the available community resources, and (3) information on physician impairment. In family medicine clerkships, however, it was decided that more comprehensive skills should be acquired, including, for example, more sophisticated intervention techniques and strategies for family support.

Although similar areas of diagnosis and medical management are covered at each level of the curriculum, the specific knowledge and skills taught are consistent with the relative competencies of students at each level. For instance, it is appropriate to teach a first-year student to take an alcohol history, but interviewing the denying and manipulative patient might not be appropriate until the third year. Thus, for a student who progresses through this curriculum, the knowledge and skills learned at each level avoid redundancy by building on previous experience with increasing complexity and sophistication.[7]

Discussion

The alcoholism teaching module developed for the third-year clerkship in family medicine has proven to be successful in meeting the needs of students and the requirements of the clerkship. From this foundation, teaching components have been developed for use at other levels of the curriculum.

The following several strategies have proved effective in this development process and may be useful to others engaged in similar enterprises:

1. The use of a simple model to guide preliminary planning and implementation activities
2. The formation of a community advisory committee to assist in the development of a teaching program in a new area
3. The use of the module format for structuring clinical and didactic experiences with the flexibility for expansion to other levels of the curriculum
4. The incorporation of teaching materials into existing courses, as opposed to the development of separate electives
5. The progressive presentation of materials from basic skills early in the curriculum through advanced concepts and techniques during clinical training

In assessing the overall process, it also became apparent that certain activities could have been accomplished in a more efficient manner. Not only should faculty development programs have been greatly expanded to provide more extended training for greater numbers of faculty who might have been attracted to alcoholism teaching, but also more effort should have been made to secure the active support of the dean's office in promoting a schoolwide interest in the alcoholism curriculum.

The program would have also benefited from a stricter adherence to the planned expansion schedule. The unexpected volume of requests for lectures and presentations on alcoholism following the initial success of the third-year module caused problems for the participating faculty and may have diluted the quality of the product. However, these were problems that were difficult to anticipate during the early stages of the project.

Alcoholism is by no means a unique problem; it can be categorized with nutrition, geriatrics, and rehabilitation medicine as an example of an important topic that is difficult to teach in an interesting and relevant way. A practical approach directed at skills development in the office setting and an orientation toward a team using hospital and community resources might be applied to any of the above-mentioned topics. The model described here can provide a framework for the development of similar curriculum design in other areas, and attention to recommended strategies and pitfalls may make the process of curriculum development in such neglected areas of medical education easier and more profitable.

The impact of this program on medical practice is, of course, impossible to assess at present. The notion that a long-term improvement in the treatment of alcoholism might be achieved through teaching practical office skills at the undergraduate level is an attractive one, but remains a question requiring further study.

Acknowledgment

This project was supported by a grant from the Kroc Foundation, Santa Ynez, California.

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