Leading Article

Alcohol education for doctors

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A conference on alcohol education at the Department of Health and Social Services (DHSS) in March (1986) under the aegis of the Chief Medical Officer and organised by Dr R. J. Wawman seemed at times like a group psychotherapy session – or a confessional, as one speaker put it. It began with five doctors – newly appointed hospital consultants or principals in general practice – each giving a ten minute account of the deficiencies in their knowledge about alcohol and its problems and of the information they would like to have had during their training in the light of their present practice. A similar pattern of ignorance was repeated by other speakers at the meeting: alcohol abuse appeared to be a closed book to most doctors.

Such ignorance is shared by all sections of the population, hence the difficulty of doing anything to combat an increasingly pervasive problem. The reason is clear: over 90% of people enjoy a drink; alcohol may be an addictive drug but it does not have the social stigma now attached to cigarettes (quite the opposite) and it does not kill as many people. Nevertheless, 8–10,000 premature deaths (Taylor, 1981) may be a minimum and up to three million individuals are thought to be at risk in the UK. Other attitudes determine doctors' responses. In training they encounter mainly the end-results of alcohol abuse, for which little can be done. A pessimistic attitude persists into practice, and indeed many doctors believe it is not their job to get involved with alcoholics. It is difficult to break down this prejudice. We recently advertised an alcohol workshop for doctors in the Thames regions: we had five replies from the 7500 practitioners circulated.

Given that doctors ought to be more active, as the DHSS conference believed, how can this be achieved educationally? Alcohol plays an important role in most cultures and an interest should be fostered early – at school as part of studies about society, economics, agriculture and health. How much general knowledge do students have when they enter medical school? As would be expected from its frequent appearance in

medical wards there is a good deal of clinical teaching about alcohol abuse but it is largely unstructured, and a more formal approach would not overburden the curriculum (Paton, 1986). We have to teach the many early warning signs rather than concentrating, as we do now, on alcohol-induced disease. Such an educational initiative might have a salutary effect on the excessive drinking for which medical students are renowned. (Are they in fact worse than their peers?)

At qualification, doctors should at least be comfortable about discussing alcohol with their patients (Barrison *et al.*, 1980); it is strange that people seem to find it more of a taboo subject than sex and death. One of the many myths surrounding alcohol is that an accurate history is impossible to elicit from someone who is drinking too much. Quantity, however, may be less important (except for purposes of research) than trying to establish how important drinking is in an individual's life. Doctors engaged in primary health care should routinely record each person's drinking habits – it only takes two or three minutes even in a busy surgery (Wiseman, 1986) – and they should be able to identify the heavy drinker and to spot those who are beginning to have problems. This applies equally to all hospital specialists since alcohol excess may be involved in any medical problem: its presence should be positively sought.

Plenty of material is available for the continuing education of doctors. Information about courses, booklets, audio-visual aids, and educational packs can be obtained from bodies like the Medical Council on Alcoholism and Alcohol Concern*. Most localities now have community alcohol teams (Alcohol Concern, 1986) whose members are keen to visit postgraduate centres and group practices to talk about their work. Alcohol is a topic which is ideally suited to a multi-disciplinary approach, and many health workers could pass on their knowledge with advantage to doctors. At least one session each academic year should be devoted to alcohol in every postgraduate centre, and another included in vocational training schemes for general practice. A designated individual might be responsible for organising such training in each health district. General practitioners, physicians and psy-

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chiatrists with an interest, and community physicians should be capable of helping to educate professions and public.

It is no good being able to diagnose an alcohol problem if the doctor is not interested in counselling or giving advice. Contrary to popular medical opinion that little can be done, various helpful strategies have been outlined (Baker *et al.*, 1986), and as many as two-thirds of heavy drinkers will cut down if their doctors advise them to (Skinner & Holt, 1983). It is also important to know what services are available locally for patients who need more specialised help (Alcohol Concern, 1986). Doctors with negative attitudes

towards alcohol misuse should examine their own response to drinking. The medical profession – a high risk group for alcohol problems – needs to abandon its present ambivalent attitude towards alcohol if it is to play its proper part in combatting a growing threat to health.

References

- ALCOHOL CONCERN. (1986). *Alcohol services: a directory for England and Wales*. Alcohol Concern: London.
- BAKER, T.F., RITSON, E.B. & HODGSON, R.J. (1986). Alcohol-related problems in the primary health care setting: a review of early intervention strategies. *British Journal of Addiction*, **81**, 23.
- BARRISON, I.G., VIOLA, L. & MURRAY-LYON, I.M. (1980). Do housemen take an adequate drinking history? *British Medical Journal*, **281**, 1040.
- PATON A. (1986). New survey of medical education. *Alcohol*

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Alcohol Concern, 305 Gray's Inn Road, London WC1X 8QF.

Concern, **2**, (no 9), 14.

SKINNER, H.A. & HOLT, S. (1983). Early intervention for alcohol problems. *Journal of the Royal College of General Practitioners*, **33**, 78.

TAYLOR, D. (1981). *Alcohol: reducing the harm*. Office of Health Economics: London

WISEMAN, S.M. (1986). Assessment of drinking patterns in general practice. *Journal of the Royal College of General Practitioners*, In press.