

Brief intervention strategies for harmful drinkers: new directions for medical education

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Recent advances in the technology of behavioural interventions for harmful drinkers have created a new role for clinical practice and new challenges for medical education. Several reports from expert committees have recommended new initiatives in the secondary prevention of alcohol problems through physician-based interventions at the primary care level. The conceptual and scientific bases for these recommendations are discussed in terms of recent studies of harmful and hazardous drinkers. The behavioural principles thought to account for the effectiveness of brief interventions are explained. Despite these promising developments, difficulties are inherent in the introduction of new technologies, especially behavioural technologies, into medical practice. A major challenge to medical education will be the development of academic programs that not only teach skills and competencies in secondary prevention but also deal with the socialization of physicians as behavioural practitioners.

In an effort to implement a public health approach to the secondary prevention of substance-related problems, efforts are now under way in several countries to link a new generation of screening technologies to low-cost early intervention strategies.¹ Part of the impetus for these programs comes from broader public health concern with the relation between lifestyle-related behavioural risk factors and disease prevalence.² Because lifestyle risk factors such as cigarette smoking, recreational drug use and heavy drinking are often amenable to behavioural interventions, increasing attention is being devoted to the dissemination of screening and lifestyle counselling techniques in primary and other health care settings. The impetus for these initiatives comes in part from the conclusions of expert committees, such as those sponsored by the US Institute of Medicine,^{2,3} the World Health Organization (WHO)⁴ and the US Department of Health and Human Services.⁵

In one recent study strong emphasis was given to the neglected role of primary care physicians and other medical specialists in the identification and early management of alcohol problems.³ Before this can be accomplished, major changes may have to be made in medical education, particularly in pediatrics, internal medicine, family medicine and psychiatry. One report recommended that practising physicians in these four specialties should be able to take a detailed drug and alcohol history, order and interpret appropriate laboratory tests, and engage patients in appropriate treatment.⁵

How effective can physicians be in the treatment of alcohol problems? Several innovative clinical trials and demonstration programs have been

initiated to evaluate brief interventions for heavy drinkers. An underlying assumption of these secondary prevention studies is that heavy drinking, which increases substantially the risk of social, medical and psychologic problems,⁶ can be managed effectively by skilled physicians who do not specialize in the treatment of alcoholism. Some of the more promising studies of how to reduce alcohol consumption are described below.

Controlled trials and program evaluations

During the 1970s there were a number of research reports evaluating the effectiveness of broad-spectrum behavioural treatment techniques with nondependent problem drinkers.⁷ In general, the results of early studies were encouraging, although the behavioural approaches were time consuming.⁸ Later studies have used a more efficient approach; referred to as behavioural self-control training, this approach typically includes specific behavioural techniques such as goal setting, self-monitoring, controlling rate of consumption, self-reinforcement and the learning of alternative behavioural competencies to substitute for drinking.⁹

This research indicates that methods that provide information, encouragement and brief counselling may be appropriate as the first intervention with the large and increasing numbers of people who drink heavily but are not dependent on ethanol. Common features of these interventions are their low cost, a modest investment of time and resources that is required, an emphasis on self-help and self-management techniques, and minimal involve-

ment of professional service providers. The results of other studies support this conclusion, particularly as it applies to medical settings.

In one investigation Kristenson and colleagues¹⁰ in Malmo, Sweden, studied middle-aged men identified as "heavy drinkers" as part of a general health screening project. Those identified as having elevated levels of γ -glutamyl transpeptidase (GGT) were randomly assigned, either to a counselling group or to a control group. Although the GGT values of both groups decreased significantly, among the intervention group there were fewer days of absenteeism, sick days and days hospitalized over a 6-year period. The study showed that simple intervention based on regular feedback about a biochemical marker had a beneficial effect on the drinking habits and physical health of a population considered at risk.

Another study, conducted in Scotland, assessed the effectiveness of brief counselling and a self-help manual when used for nonalcoholic, socially stable problem drinkers identified in a general hospital.¹¹ Screening was conducted by a trained nurse during a 10-minute interview that asked about drinking habits, medical history and social background. Although both the counselling and control groups reported significantly less alcohol consumption at the 1-year follow-up evaluation, the counselling group indicated fewer alcohol-related problems and a greater reduction in GGT levels.

Another study conducted in Scotland involved primary care physicians in the identification and management of problem drinkers.¹² Known as the DRAMS project (*d*inking *r*esponsibly *a*nd *m*oderately with *s*elf-control), the program used screening procedures, interview guidelines and patient-education materials aimed at reducing the patient's alcohol intake to nonhazardous levels. After the DRAMS package was introduced to general practitioners, 52 participating physicians reported counselling 161 eligible patients. Though there was a significant increase in the identification of alcohol-related cases during the project, the evaluation indicated that only a minority of the physicians actively used the package.

Elvy and associates¹³ conducted a trial of referral to treatment among heavy-drinking, nondependent general hospital patients in New Zealand. Problem drinkers identified by hospital screening were assigned at random either to a referral condition in which they were confronted with their drinking-related problems and referred for alcohol counselling or to a control condition in which no action was taken. A substantial number (62%) of the patients who were offered treatment accepted the referral, and those referred showed significantly greater improvement after 12 months.

Wallace and collaborators¹⁴ conducted a con-

trolled trial in England to determine the effectiveness of advice given to heavy drinkers by general practitioners. Patients either received advice to reduce their alcohol consumption or were assigned to the control condition, in which advice was not offered. One year later there was a two-fold reduction in alcohol consumption in the experimental group that was positively associated with the number of advice sessions attended.

The WHO Amethyst Project is a recently completed multicentre trial of advice for heavy drinkers.¹⁵ Centres in 10 countries used a randomized design to examine the effects of either simple advice (requiring approximately 5 minutes) or brief counselling (requiring approximately 20 minutes) to reduce consumption among heavy drinkers. Though the results of this ambitious project are not yet available, preliminary findings suggest the beneficial implementation of this approach in widely different cultural settings.^{15,16}

Although the concept of secondary prevention is attracting widespread interest, the development of effective and inexpensive early interventions is still in its formative stages, and most programs have been experimental. Some have been initiated as demonstration projects, and many have not been evaluated rigorously enough to provide evidence of their likely effect in clinical practice. Before these findings can be used to develop educational programs for medical practitioners, it will be necessary to understand the behavioural processes that underlie the effectiveness of these interventions as well as the practical barriers that may limit the widespread initiation of early intervention. As indicated by the results of demonstration projects and clinical trials, there are several logistic, technical and professional issues that need to be addressed before the promising findings from early intervention research can be applied to clinical practice and public health programs.

Behaviour change strategies

The behaviour change strategies that have been used in early intervention share a number of elements and theoretical assumptions.^{15,17} In general, the more promising interventions incorporate behavioural, cognitive and social psychologic principles.

When the patient is ambivalent about taking action about a drinking problem, the best strategies are those that increase motivation and secure a firm commitment to change.¹⁷ For example, it is considered desirable to communicate the belief that a given course of action, such as achievement of moderate drinking or abstinence, will lead to a particular outcome such as improved health. To the extent that these response-outcome expectancies are positive,

patients will be more likely to attempt to modify their drinking.

Another motivating technique is the creation of cognitive dissonance. A pervasive characteristic of human behaviour is the tendency to be consistent in thought, feelings and action.¹⁸ Dissonance arises when there is inconsistency between two or more cognitive elements, such as a favourable attitude toward alcohol and knowledge about negative consequences of heavy drinking. When knowledge of one's behaviour is not consonant with a belief, dissonance theory predicts that the patient will change his or her behaviour to reduce dissonance.

Attitudes may be changed by various means. One of the most logical methods is social influence. Three distinct processes of social influence are compliance, identification and internalization.¹⁹ *Compliance* occurs when one person accepts influence from another person, such as a physician, because such behaviour is often instrumental in gaining some reward or avoiding displeasure. *Identification* occurs when a person changes his or her behaviour — from heavy drinking to moderation, for instance — to solidify a satisfying self-defining relationship with another person. One form of identification is when a patient behaves in accord with the physician's expectations by adopting the latter's advice and suggestions. Another form is the patient's attempt to conform to the norms of a desirable group, such as moderate social drinkers. Compliance and identification do not require that the behaviour or attitude itself be instrumentally satisfying to the patient. In the case of *internalization*, however, a person accepts influence because the induced behaviour is congruent with his or her value system. It is generally believed that internalization produces more lasting behavioural change.

In trying to change attitudes and motivate patients to modify high-risk behaviour, the physician can use several bases of social power.²⁰ For example, the more the physician is perceived as an *expert* by the patient, the more likely his or her advice will be accepted. This means that physicians should emphasize their expertise in matters relating to alcohol and health. Change is also more likely when the physician is perceived as having a legitimate right to dictate the patient's health-related behaviour. This can be facilitated by persuading the patient to accept the role of being at risk and by interpreting information about the patient's drinking in an objective, nonthreatening way. The physician will exercise *referent* power to the extent that he or she is liked by the patient. A warm, friendly attitude will facilitate this kind of relationship. *Reward* power is based on the perception that the physician has the ability to mediate desirable outcomes or consequences. This kind of power is enhanced when the physician's

skills are considered valuable for achieving desirable goals, such as better health, fewer accidents and improved interpersonal relationships.

Several practical procedures have been developed to enhance social influence, implement attitude change, increase motivation and modify expectancies — for example, motivational interviewing, information giving, psychologic contracting and negotiated goal setting. Motivational interviewing collects information from the patient so as to promote self-esteem, increase feelings of self-efficacy, generate cognitive dissonance and direct dissonance toward behaviour change.¹⁷ This can be accomplished during a clinical interview by showing empathy when drinking or alcohol-related problems are discussed; providing reinforcing statements when the patient admits alcohol-related problems to build awareness; reinterpreting interview information to generate better recognition of an alcohol problem; eliciting self-motivational statements on the need to change; providing the patient with objective feedback; and giving expert interpretation of the nature and extent of alcohol-related risk.

Once the patient has been engaged in self-exploration and evaluation, it is sometimes valuable to generate additional dissonance by providing information about the unexpected hazards and consequences of drinking. To the extent that this information can be personalized and made to seem consistent with the patient's situation, the negative reaction that is often produced by fear-arousing communications can be avoided.

Another type of information giving is designed to motivate the patient through social comparison. Instead of dwelling on the sordid picture of end-stage alcoholism, it may be better to point out what kinds of drinking are typical of moderate social drinkers. This provides the problem drinker with a normative basis for social comparison, and may increase motivation to be like others with whom the drinker would prefer to identify. Goal setting is another approach incorporated into behaviour change programs. Self-regulation of human behaviour is influenced significantly by setting specific, concrete objectives. Goals that are vague, difficult or unattainable can cause frustration and feelings of failure. In contrast, achievable goals lead to feelings of competence and are intrinsically rewarding. To influence current behaviour, ultimate goals should be translated into a number of specific, short-term goals, each of which is connected to an attainable objective or reward. For example, instead of making vague suggestions that continued liquor consumption will result in liver damage, the physician encourages the patient to switch to low-alcohol beer. This specific task is likely to lead to a significant reduction in average alcohol intake, an objective that

contributes to the overall goal of moderation or eventual abstinence.

Related to goal setting is the importance of keeping the intervention simple and brief. The more an intervention is perceived as costly, time consuming and difficult, the more the patient may feel that the goal is not worth the effort. Finally, it is likely that involving the patient in the choice of a drinking goal, such as moderation versus abstinence, will increase the chances of internalization.

Once the patient has been engaged in self-evaluation, has experienced cognitive dissonance and has expressed a desire to strive for either moderation or abstinence, the physician should secure a firm commitment to follow through on these good intentions. This can be accomplished by a commitment agreement or psychological contract. At the very least, the patient should summarize several specific and achievable goals and the means to achieve them — for instance, to reduce drinking to no more than 4 days a week. A better method is to ask the patient to develop a written plan that can be referred to at future meetings. Such a psychological contract formalizes expectations and establishes a long-term behavioural plan as the basis for future action.

Although the theoretical rationale and specific strategies for motivation and commitment may seem complicated, many of them can be incorporated easily into the framework of a 20-minute interview devoted to other kinds of health and lifestyle behaviour as well as drinking. Once the patient has been engaged in this process, the next stage is to formulate a realistic plan for implementing change. In successful brief-intervention programs, this action stage includes a systematic exploration of antecedents and consequences of drinking behaviour (functional analysis), the development of expectations of self-efficacy and success, training in various coping skills, and the development of alternative activities that are likely to be incompatible with, or substitute for, drinking.

Functional analysis is a careful review of both antecedent events and expected consequences of drinking.²¹ Addictive behaviours are influenced by various antecedent or setting events. When faced with a specific risk situation — anxiety, social pressure — a person is influenced by the consequences of previous learning experiences. If these high-risk situations can be identified, strategies can be devised to deal with them. Some can be avoided by changing a habit, such as stopping drinking with heavy-drinking friends. Others, such as social pressure to drink at a tavern, can be anticipated and defused at an early stage. High-risk situations that are difficult to avoid, such as tiredness, stress or interpersonal conflicts, require specific coping strate-

gies. Approaches that use anticipation, avoidance and coping are called self-management or self-control strategies.²² Self-management involves not only coping with particular high-risk situations but also more global strategies directed toward modification of a hazardous lifestyle.

Various self-management strategies have been developed.^{9,21,23} Keeping a behavioural record, such as of the number of drinks consumed daily, tends to increase awareness of habitual actions. This feedback has a significant influence on motivation. Rewarding oneself for positive behavioural changes, perhaps with a present or an outing, also seems to be effective. Another cognitive strategy is to formulate and rehearse long-term positive or negative consequences. The more these long-term consequences are kept in mind the more they influence current behaviour.

Focusing on lifestyle changes that result in alternative activities is another method of dealing with high-risk situations. The goal is to reduce the level of risk associated with loneliness, alienation and boredom. Many “positive addictions”, such as jogging, meditation, sports, games and yoga, have been proposed as substitutes. To the extent that social relationships play a large part in alcohol use, one could increase social reinforcements so that when a person is about to drink heavily he or she is made aware that social reinforcement will be lost.

Lack of support from the physician can be associated with failure to comply with treatment regimens. Encouragement, reassurance and tangible help may increase a patient’s self-competence and motivation to adhere. A friendly encouraging attitude by the physician during follow-up visits may help to maintain the gains demonstrated during an initial session.

The challenge to medical education

The promising developments I have described in the design of brief-intervention techniques and the demonstration of their effectiveness pose a major challenge for the medical profession in general and for medical education in particular. Conditions under which practising physicians will learn and apply these techniques to routine medical practice must be established. Unfortunately, there is ample evidence that physicians do not use screening and brief interventions with their patients.^{24,25} This research suggests that medical practitioners lack the motivation and skills to deal directly with patients’ alcohol abuse. If the reasons for this reluctance can be identified, it may be possible to improve medical education and remove the structural constraints that inhibit action.²⁶

One possible source of difficulty is in the physi-

cian-patient relationship; it comprises some very complex interpersonal processes that range from psychologic phenomena, such as the patient's anxiety and the physician's personality, to social features of the medical encounter, such as the health care setting and social class differences.

Empiric studies of physician-patient interactions provide clues to why alcohol abuse is so neglected in medical settings. For example, a number of researchers have studied the communication patterns between patients and physicians and how they often result in gaps in disclosure of critical information.²⁶ Other studies have focused on distortions of meaning associated with different language styles.^{27,28} One style, termed task oriented or physician centred, is characterized by information gathering in an efficient, impersonal way without providing significant feedback to the patient. The other is person centred and is characterized by greater friendliness, more empathy and explicit awareness of the patient's feelings and medical complaints. The data suggest that task-oriented physicians are less sensitive to patients' feelings and subtle requests for help and tend to be less open in their disclosure of relevant medical information.²⁸ This style of physician-patient communication also has been associated with noncompliance with the physician's advice.

These styles of communication may have important implications for the identification and management of people with alcohol-use disorders. First, task-oriented physicians may be less interested in asking questions about alcohol use because it is often considered irrelevant to the immediate medical problem. Second, task-oriented physicians may be less capable of eliciting sensitive information from patients who are concerned but embarrassed about their drinking. Third, they may be unwilling to discuss alcohol even when they realize it is a potential problem because this area is considered beyond the realm of strict biomedical practice.²⁵ Finally, these physicians may invite noncompliance if their advice about drinking is given in a confrontational or nonsympathetic way. Indeed, a study of unspoken cues in physician-patient interactions found that physicians' feelings about alcoholic patients may affect their success at referring patients for treatment.²⁹ Patients were less likely to comply with an emergency department referral to a clinic that treated alcohol problems when their physician's speech expressed anger and were more likely to accept referral when anxiety was conveyed, perhaps because it was interpreted as concern.

There are a number of other potential barriers to the successful implementation of physician-initiated screening and intervention for alcohol-use disorders: the often disguised nature of drinking in the presentation of medical problems, the limitations

of time and resources imposed by medical practices, and the perceived role of the physician in modern society.²⁵ Because alcohol problems are not the main reason why most heavy drinkers seek medical attention, there is a tendency for both patient and physician to collude in a conspiracy of silence, even when drinking is the obvious cause of the presenting problem. Even when it is not, physicians are often expected to treat illness rather than prevent it, an expectation that is reinforced by fee-for-service financing mechanisms.

At a broader level of analysis, it is also important to consider the pervasive influence of the socially defined roles of physician and patient in western industrial societies. Sociologist Talcott Parsons³⁰ suggested that society has specific expectations of people who assume the role of physician. This role, learned in part during the formative years in medical school, is invested with the responsibility of returning sick people to full function. Major components of the role include affective neutrality, universalism and functional specificity. Affective neutrality prevents the physician from becoming emotionally involved in the patient's illness to maintain objective judgement. Universalism means that all patients are considered equal, and medical decisions should be guided only by technical medical criteria. Functional specificity implies that the physician's role should be restricted to medical matters, personal or social considerations being irrelevant. It is clear that Parsons' analysis of the physician's role is consistent with the dominant mode of task-oriented communication observed in studies of patients and physicians. Complementing the physician's societal role is that of the patient, who is expected to be passive, dependent and cooperative by accepting the physician's guidance.

As with the evidence dealing with task-oriented communication patterns, it has been suggested that the physician-centred role in medicine may not be appropriate for all medical encounters. Although the physician-patient roles may facilitate treatment of medical emergencies, Szasz and Hollander³¹ have proposed that "mutual participation" may be preferable in the treatment of chronic illnesses such as diabetes, where patients are required to carry out much of the treatment program themselves under medical consultation. It seems that a mutual participation relationship would also apply to the management of alcohol-use disorders in medical settings.

How medical education can meet the challenge

At least two areas of medical education need to be considered in the widespread dissemination of brief interventions in routine medical practice. First

is a mastery of skills and knowledge pertaining to the identification and management of alcohol-use disorders. Second is the inculcation of a different set of attitudes and values that help to define the role of the physician.

It is important to emphasize that many of the traditional concepts about alcoholism that have been so instrumental in advancing tertiary treatment and removing the stigma associated with treatment for alcoholism are not germane to the teaching of early identification and brief interventions. Although the disease concept of alcoholism may be the most appropriate model to guide the diagnosis and management of severe alcohol dependence, the research and theory reviewed here suggest that brief interventions for harmful drinkers require the teaching of an alternative, if not parallel, model that views alcohol problems independently of alcohol dependence, at least at the early stage of development. This model suggests that screening should focus on hazardous patterns of alcohol consumption as they relate to the very common medical and psychosocial consequences of heavy drinking, such as accidents, traumatic injury, mood disorders, hypertension and gastrointestinal problems. This approach is in no way incompatible with a more traditional disease model that uses screening as a means of case finding so that the more advanced patient may be referred to proper care for detoxification and rehabilitation. And though skills and competencies should be taught in both models, it is clear that medical students need as much training in how to conduct brief interventions with harmful drinkers as they do in the diagnosis and referral of dependent alcoholic patients to specialized services.

Training of physicians in the recognition and management of heavy drinkers should take the form of both didactic and experiential learning. In addition to concepts, screening procedures and counseling skills, it is extremely important for medical students to practise these skills by using such techniques as role playing and interviews with simulated patients. Particular attention should be devoted to modelling the various elements of effective counseling, such as personalized feedback, empathic communication, motivational interviewing, negotiation of drinking goals and mutual participation in the intervention plan.

The second component of medical education is the socialization of physicians in a way that makes them more effective agents of behavioural change. There is probably no course or practicum that can socialize medical students in the role of the patient-oriented physician. To the extent that there are important formative experiences in the making of a physician that contribute to the development of affective neutrality, universalism and functional

specificity, these influences may be tempered with socialization experiences that promote active listening, thorough history taking, affective communication and a more sympathetic concern for the patient's complaints. One logical way of strengthening these attitudes and values is to familiarize medical students more with the social and behavioural sciences and to balance their orientation to the biomedical model with equal exposure to a broader view of disease and illness that takes account of cultural, social and psychologic factors. Within this sociocultural model of medicine, students can be taught to "negotiate" the patient's drinking problem by reaching a mutual understanding about what is often an ambiguous and unclear set of symptoms. Instead of breaking down denial by confronting the patient, the physician must engage the patient in a process of self-diagnosis that may lead to earlier recognition and more rapid response to an incipient drinking problem.

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References

1. Babor TF, Ritson EB, Hodgson RJ: Alcohol-related problems in the primary health care setting: a review of early intervention strategies. *Br J Addict* 1986; 81: 23-46
2. *Healthy People: the Surgeon General's Report on Health Promotion and Disease Prevention: Background Papers* (DHEW [PHS] publ no 79-55071A), Institute of Medicine, Washington, 1979
3. *Broadening the Base of Treatment for Alcohol Problems*, Natl Acad Pr, Washington, 1990
4. Arif A, Westermeyer J (eds): *Manual of Drug and Alcohol Abuse: Guidelines for Teaching in Medical and Health Institutions*, Plenum Pr, New York, 1988
5. Alcohol, Drug Abuse and Mental Health Administration: *Consensus Statement from the Conference on Alcohol, Drugs and Primary Care Physician Education: Issues, Roles, Responsibilities. November 12-15, 1985, Rancho Mirage, California*, Dept of Health and Human Services, Rockville, Md, 1985
6. Babor TF, Kranzler HR, Laueran RJ: Social drinking as a health and psychosocial risk factor: Anstie's limit revisited. In Galanter M (ed): *Recent Developments in Alcoholism*, Plenum Pr, New York, 1987
7. Miller WR, Hester RK: Treating the problem drinker: modern approaches. In Miller WR (ed): *The Addictive Behaviours: Treatment of Alcoholism, Drug Abuse, Smoking and Obesity*, Pergamon, Oxford, 1980: 11-141
8. Miller WR, Taylor CA, West JC: Focused versus broad-spectrum behavior therapy for problem drinkers. *J Consult Clin Psychol* 1980; 48: 590-601
9. Miller WR, Munoz RF: *How to Control Your Drinking*, Prentice-Hall, Englewood Cliffs, NJ, 1976
10. Kristenson H, Trelle E, Hood B: Serum of glutamyl-transferase in screening and continuous control of heavy drinking in middle-aged men. *Am J Epidemiol* 1982; 114: 862-872
11. Chick J, Lloyd G, Crombie E: Counseling problem drinkers in medical wards: a controlled study. *Br Med J* 1985; 290: 965-967
12. Heather N: Change without therapists: the use of self-help

- manuals by problem drinkers. In Miller WR, Heather N (eds): *Treating Addictive Behaviors: Processes of Change*, Plenum Pr, New York, 1986: 331-359
13. Elvy GA, Wells JE, Baird KA: Attempted referral as intervention for problem drinking in the general hospital. *Br J Addict* 1988; 83: 83-89
 14. Wallace P, Cutler S, Haines A: Randomized controlled trial of general practitioner intervention in patients with excessive alcohol consumption. *Br Med J* 1988; 297: 663-668
 15. Babor TF, Korner P, Wilber C et al: Screening and early intervention strategies for harmful drinkers: initial lessons from the Amethyst Project. *Aust Drug Alcohol Rev* 1987; 6: 325-339
 16. Acuda SW: Intervention: Is simple intervention really simple? In Waahlberg R (ed): *Proceedings of the 35th International Congress on Alcoholism and Drug Dependence*, vol 1, National Directorate for the Prevention of Alcohol and Drug Problems, Oslo, 1988: 1-14
 17. Miller WR: Motivational interviewing with problem drinkers. *Behav Psychother* 1983; 11: 147-172
 18. Festinger L: *A Theory of Cognitive Dissonance*, Har-Row, New York, 1957
 19. Kelman HC: Processes of Opinion Change. *Public Opin Q*, 1961; 25: 57-78
 20. French JRP, Raven BH: The bases of social power. In Cartwright D (ed): *Studies in Social Power*, U of Mich Pr, Ann Arbor, Mich, 1959: 118-149
 21. Hodgson RJ, Miller PM: *Selfwatching: Addictions, Habits, Compulsions*, Century, London, 1982
 22. Goldfried MR, Merbaum M: *Behavior Change through Self-Control*, Holt, New York, 1973
 23. Robertson I, Heather N: *So You Want to Cut Down Your Drinking?*, Scottish Health Education Group, Edinburgh, 1982
 24. Barchha R, Steward M, Guze S: The prevalence of alcoholism among general hospital ward patients. *Am J Psychiatry* 1968; 125: 681-684
 25. Lisansky ET: Why physicians avoid early diagnosis of alcoholism. *N Y State J Med* 1975; 75: 1788-1792
 26. Hauser ST: Physician-patient relationships. In Mishler EG, AmaraSingham LR, Hauser ST et al (eds): *Social Contexts of Health, Illness, and Patient Care*, Cambridge U Pr, New Rochelle, NY, 1981: 104-136
 27. Plaja A, Cohen S: Communication between physicians and patients in outpatient clinics: social and cultural factors. *Milbank Mem Fund Q*, 1968; 46: 161-213
 28. Byrne PS, Long BE: *Doctors Talking to Patients*, HMSO, London, 1976
 29. Milmo S, Rosenthal R, Blane HT et al: The doctor's voice: postdoctor of successful referral of alcoholic patients. *J Abnorm Psychol* 1967; 72: 78-84
 30. Parsons T: *The Sick Role and the Role of the Physician Reconsidered*, *Milbank Mem Fund Q*, 1975; 53: 257-278
 31. Szasz T, Hollander M: A contribution of the philosophy of medicine: the basic models of the doctor-patient relationship. *Arch Intern Med* 1956; 97: 585-592

Preventing alcohol problems: survey of Canadian medical schools

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In preparation for a national conference on medical education in the prevention of alcohol problems, a survey of conference participants was conducted. Participants were undergraduate and postgraduate representatives from each Canadian medical school and representatives from 11 provincial and territorial alcohol and other drug agencies. There was agreement that physicians and medical schools have important roles in prevention and treatment of alcohol problems, with "traditional" medical roles seen as the most important. Current training is variable and was seen as inadequate, with more time devoted to treatment than prevention. To correct this situation, renewed priorities and faculty leadership are needed. Respondents felt that there should be uniform standards for assessing undergraduate students' skills in dealing with alcohol problems. Provincial alcohol and other drug agencies are underused in medical education in the prevention and treatment of alcohol problems.

The goals of the national conference "Preventing Alcohol Problems: the Challenge for Medical Education" (held at Niagara-on-the-Lake, Ont. Oct. 16-17, 1989) were to "ensure that physicians at the undergraduate and postgraduate levels of training acquire the necessary knowledge, attitudes and skills to prevent alcohol problems in clinical practice and to play leadership roles in community efforts to prevent alcohol problems." Representatives of Canadian medical schools and government

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The views expressed in this article are those of the authors and do not necessarily reflect those of the Addiction Research Foundation of Ontario.

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