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The General Practitioner's Role in Alcoholism

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A FEW years ago the United States Public Health Service estimated that there were 400,000 cases of tuberculosis in the United States. At the same period it was estimated by scientific statisticians that there were 4,000,000 cases of alcoholism throughout the nation. This figure, which is now on the conservative side, is mentioned only to give some idea of the immense size of the problem of alcoholism: ten times as many cases of alcoholism as there are of tuberculosis. It pervades every walk of life, both sexes, and every condition of society. The picture of the alcoholic as a skid row character is entirely misleading. Less than 10% of these four million are on skid row. The vast majority are still living at home, are still working more or less, and are still affecting the lives of the families with whom (or on whom) they live.

Physicians sometimes think of alcoholics in terms of the late chronic type, who are admitted to the wards of the big city hospital from the alleys and hovels of skid row, who are on the verge of delirium tremens, and who have little or nothing to return to on release from the hospital. This is not the average, typical picture of alcoholism as that condition is understood today. From such a false picture there can result nothing but misconceptions as to the role of the average physician in meeting the widespread medical problem of alcoholism.

Naturally, it would be presumptuous for a layman to tell physicians what is and what is not a medical problem. In writing at all about the medical aspects of alcoholism, I feel that my position is merely that of a reporter. I have been in touch with large numbers of alcoholics during the past ten years, have often worked in cooperation with their physicians, and have been in contact with the medical experts in this field both on the lecture platform and through their writings in the medical journals. This enables me, perhaps, to be of some service to the readers of LINACRE QUARTERLY by reporting to them what the experts are saying about alcoholism and about the role of the physician in this extremely widespread public health problem. And so I have accepted the invitation of the editors to contribute this article. My remarks are not addressed, therefore, to the specialist — whether psychiatric or medical — but rather to the general practitioner, and those other physicians who frequently see these cases in the course of their own practice whatever their specialty may be.

Alcoholism as a Sickness

That alcoholism is a medical problem, at least in part, is now generally recognized. The educational work of the National Committee on Alcoholism, the Yale Center of Alcohol Studies, and of other agencies has not been without fruit. The general public has heard over and over again: 1) that the alcoholic is a sick person; 2) that the alcoholic can be helped; 3) that he is worth helping, and 4) that this is a medical and public health responsibility. More even than the general public the profession itself now stands committed to the concept of alcoholism as a sickness. For instance, the World Health Organization and the American Medical Association, to name but two influential bodies, accept that concept.

The idea has encountered some resistance, however. One reason is that it is impossible at present to identify a definite disease entity which all alcoholics have in common. Alcoholism is not like diabetes or tuberculosis or the various heart diseases in this respect. Exaggerated claims of that kind merely put obstacles in the way of acceptance of alcoholism as the sort of illness it is.

Another objection to the illness concept is raised by those who feel that this gives the alcoholic a good reason to go on drinking, and say: "I can't help it; I'm a sick man." In my own observation I have seen a few cases of this kind, but very few. It is not an excuse made by the vast majority of alcoholics who are still drinking. For the vast majority of these do not believe they are alcoholics themselves. When they read or hear about alcoholism as a sickness they invariably think it is somebody else who has the sickness. But when they finally learn that they themselves have it, they learn at the same time that it is a sickness they can do something about, a sickness that can be arrested if they will take the necessary steps to arrest it.

At all events the primary question is not whether the alcoholic will abuse the sickness concept or whether it is good tactics to tell him that he is sick. The primary question is whether it really is a sickness. The truth of the matter comes first; tactics afterwards. Actually, the sickness concept has worked better than anything else in getting alcoholics to do something about their drinking.

I believe that the medical profession in general and psychiatry in particular are the proper judges of what the label "sickness" means, and that they are the proper judges as to whether the condition alcoholism deserves that label. At present the overwhelming majority of physicians concede that alcoholism is a medical problem, and I have never come across a single medical expert in the alcohol field who is not convinced that the alcoholic is a sick person who deserves to be treated as a patient. Medical associations and medical schools are now following the lead of the American Medical Association in this respect.

Perhaps the most telling reason for looking at alcoholism as a sickness is the simple fact that an alcoholic can never learn to drink normally, no matter how hard he tries. On this point the experts are unanimous, and it is absolutely agreed that the practical goal of treatment must be complete abstinence. After years of sobriety an alcoholic will react normally if he starts drinking again. Why is this so unless there is something wrong with him? Unless there is something inside him, physiological or psychological or both, that makes him react that way? That something, whatever it is, is rightly called pathological.

The explanations why this is so, and the whole question of etiology, leave much to be desired, as far as I can gather from the literature. Researchers in physiology have not been able to agree so far on a clear, definite, organic or functional pathology which afflicts all or most alcoholics. But some of them believe that the abnormal drinking of some alcoholics results partly from a bodily pathology, and still more believe that in many or most alcoholics, once they have become addicts, physiological changes have occurred which prevent them from ever becoming normal drinkers. On the psychological side the causation is also obscure, although psychological explanations are in the ascendancy at the present time. It is much easier, at least, to point to some psychological trait, for instance a neurotic trait, as a contributing factor to the abnormal drinking, than it is to identify a bodily pathology.

But whatever the causes, it seems clear that the psychological and/or physiological mechanisms involved in addiction deserve to be called pathological. The alcoholic, once he has become an addict, that is a compulsive drinker, has acquired a dependence on alcohol which is beyond his power to control, unaided. This addiction can often be as strong and sometimes stronger than drug addiction. He is the victim of a habit so severe and so strong that it has assumed pathological proportions.

It is precisely at this point, I think, that the most persistent resistance to the sickness concept occurs. Alcoholism involves, as a general rule, conduct and misconduct, including the excessive drinking itself, which at first sight looks to the ordinary person as though it were within the power of the drinker to control. Even the alcoholic himself goes on believing for years that he "can take it or leave it," when it is obvious to everyone else that he is incapable of drinking moderately and has lost control. And since the compulsion to drink is not absolute and uninterrupted, but takes over with more or less frequency and more or less force, the question of the alcoholic's control on a particular occasion, and the consequent degree of his moral responsibility, is never an easy one. But no one who has a wide acquaintance with these problems in the concrete believes the alcoholic merely has to use his will-power in order to stop drinking. No one believes that he inflicts the agonies of a long drinking career on himself out of sheer obduracy and willfulness. There is something wrong with him which

cannot be explained in merely moral terms.

Perhaps self-indulgence has degenerated into addiction. But once the addiction or compulsion has set in, there is a new problem. It is no longer the comparatively simple moral problem of deliberate drunkenness. It is the complex problem of alcoholism, which includes moral problems, but cannot be reduced to them. And because it is such a complex pathology, there is a growing tendency to describe alcoholism as a triple sickness, a sickness of body, of mind, and of soul.

Naturally, I would be the last to minimize the sickness of the soul. But if alcoholism is a sickness in the medical sense, too, and if more than four million Americans have it, then the average physician will see alcoholics frequently. He will be face to face with the medical responsibility involved. He will have an important medical role to play.

The Role of the General Practitioner

What role is the general practitioner expected to play when he meets up with cases of alcoholism?

First of all it is a *cooperative role*. If alcoholism is a complicated and many-sided condition, if it involves sickness of body, mind, and soul, and if its arrest often depends also on socio-economic factors, then obviously the physician will rarely be in a position to handle the whole thing by himself. It is within his competence to treat the bodily needs of his patient, whatever they are, but he will usually have to refer the patient to other persons or other agencies for other aspects of his treatment. This referral requires a professional knowledge of available resources, and more than ordinary tact. It is not just a question of knowing the name of another doctor and giving it to the patient. More will be said about referral later.

It is the physician's task, therefore, to treat the acute alcoholic when he needs medical treatment, to treat severe hangover, to prevent delirium tremens and convulsions. When an alcoholic's condition is complicated by the so-called diseases of alcoholism, such as cirrhosis, pellagra, and all the others (as it is, they say, in about one quarter of the cases of alcoholism in the United States), the physician is naturally the one to manage this part of the problem. There is much literature on the treatment of acute alcoholism.[1]

The long range treatment of the alcoholic may also have its medical aspects. Recently developed drugs like disulfiram (Antabuse) have greatly increased the physician's resources and success in treating the chronic condition. Still more

[1]See for example: Feldman and Zucker, "Present-Day Medical Management of Alcoholism," *Journal of the American Medical Association*, 153 (Nov. 7, 1953) 895-901. Reprints of this article and further literature on treatment are available from the National Committee on Alcoholism, Suite 454, New York Academy of Medicine Building, 2 East 103 St., New York 29, N. Y. The Yale Center of Alcohol Studies, 52 Hillhouse Ave., New Haven, Conn., maintains *The Abstract Archive of the Alcohol Literature*, and can furnish information on current materials concerning treatment and other aspects of alcoholism.

recently hopes have been raised that the new tranquillizers, such as chlorpromazine (Thorazine) and meprobamate (Miltown) will prove useful. It is generally noted, however, that all these drugs are merely adjuncts in an overall program of therapy. This long range medical treatment is more often (but by no means exclusively) undertaken by physicians who are specializing in alcoholism or at least have a special interest in it.

In other words, the cooperative role of the general practitioner does not ordinarily include the long term therapy of the alcoholic. Everyone is well aware (except, in many cases, the alcoholic himself) that recovery from an acute episode is only the beginning of the battle, and that eventual permanent recovery requires a great deal more. But perhaps it happens too often that a false idea of the long range prospect is engendered in the mind of the patient when he hears from his physician: "Now I've got you well again; the rest is *up to you*." Or "I can sober you up; but staying sober *is your own job*." Or "Now you're *on your own*." Very few alcoholics ever recover on their own. The vast majority need continued help, though often enough it is not continued medical help. Perhaps it is spiritual, perhaps it is psychiatric, perhaps it is social. Often it is all of these.

The program of Alcoholics Anonymous has been more successful in the permanent contented recovery of large numbers of alcoholics than anything else about which we know. It offers help to alcoholics that they cannot get anywhere else. It does not cost anything and it works. It is a mistake for the physician to give his patient the impression that his long range recovery is up to himself, as though he can remain sober merely by deciding to, and by exercising his will-power. It is not ordinarily the practitioner's job to conduct long range therapy himself, but he must be forthright in making it clear to the patient that he is suffering from a progressive and insidious disease, and that he needs continued outside help. The physician must be skillful in indicating where he can get it. A.A. is one of his best resources.

This brings us to what, in my opinion, is by far the most important contribution the average physician can make. *When he encounters the alcoholic, he can diagnose his alcoholism*. But to do it he requires: 1) the knowledge to make a diagnosis of alcoholism, and 2) the courage and tact to communicate the diagnosis tellingly to the patient. Since this is a cardinal point in the whole cooperative effort to do something about alcoholism, let us explore these ideas a little further. Diagnosis is a key factor.

Knowledge to Make the Diagnosis

Frequent complaints are heard among workers in the field that many doctors are not well-informed about alcoholism. In fact, they say it is often hard to find a non-specialist to whom they feel safe in referring the alcoholic patient for the medical part of his

treatment. They are afraid the physician may just sober him up, "give him a good talking to," and tell him he is on his own. Or tell him to "drink like a gentleman," or "drink only beer," or "use your will-power and stop after two drinks." Or he may prescribe barbiturates for the hangover period without realizing the special precautions that are imperative when giving alcoholics any sedation. Barbiturate addiction is a distressingly frequent complication among alcoholics today.

Or the doctor may even tell the patient he "is not an alcoholic," meaning by that, perhaps, that he is not a chronic alcoholic in the medical sense, which formerly limited that term to one whose excessive drinking had reached the point where it was complicated by one or more of the so-called diseases of alcoholism. The prevailing usage today, adopted internationally by the World Health Organization expert committee on alcoholism, and by most specialists in the field, gives a much broader meaning to the term "alcoholic." It is estimated that in the United States only one in four alcoholics has one of the complicating diseases. It is this equivocation in terminology that leads to many misunderstandings.

But whether such complaints are justified or not, it remains true that physicians, like educators, clergymen and everyone else, including the experts, still have a lot to learn about alcoholism. The medical schools recognize this and are beginning to give specific attention to this subject in their curricula. Professional scientific journals and county medical societies more and more frequently discuss the problem for their readers and their members. An organization like the National Committee on Alcoholism stands ready to supply members of the medical profession with a limited amount of up-to-date literature, and to recommend pertinent materials. Physicians are gradually being put in possession of the information they need in order to make a diagnosis of alcoholism.

Actually, is it such a difficult thing to do? It is, if the diagnosis is going to be made on the basis of some theory as to the causation of the condition. As already mentioned, the etiology is obscure. No one has isolated a psysiological entity or a psychological trait which *is* alcoholism.

But it is not difficult merely to describe the alcoholic in terms that distinguish him, for practical purposes, from other excessive drinkers who are not alcoholics. This is the fundamental thing, both for the purpose of clinical classification, and for the purpose of long range therapy. Several such descriptions are available. The one I suggest here fairly describes and distinguishes the vast majority of those persons who are called alcoholics nowadays by physicians, psychiatrists, lay therapists, specialists, A.A.'s and others working in the field. The alcoholic has these three traits: 1) *Excess.* He has been drinking excessively over a period of years. 2) *Problems.* He has serious life problems caused by or connected with his excessive drinking. 3) *Compulsion.* He does not stop drinking completely even when he wants to and tries to, unless he gets outside help. When he tries to drink moderately he fails in spite of sincere efforts to stay within the bounds of moderation.

Excess is a matter of degree. Some alcoholics get completely drunk only rarely, but they do get thoroughly and frequently tight. Some get drunk on rather small amounts, some on large quantities. The reason why the "period of years" is mentioned is that sometimes wild drinking over shorter periods turns out to be merely a passing phase, and such drinkers settle down and learn how to drink moderately. Hence, it may be difficult to be sure of a diagnosis of alcoholism except on the basis of a somewhat extended drinking history. Naturally, it is highly desirable that alcoholism be recognized as early as possible. But even if it could be recognized from the first drink (or before) it would probably be pretty hard to convince a patient that he had alcoholism except on the basis of his own continued, abnormal drinking behavior.

Problems are a matter of degree, too. They range all the way from a serious disruption of family harmony, through loss of job, or of health, loss of moral ideals, loss of faith, of self-respect, commitment to jails and institutions, etc., all the way down to skid row. It is very important for the physician to recognize that there are many, many alcoholics who have not yet seriously injured their health, or social position, and who are very far indeed from skid row.

It is true that experienced A.A.'s (those retired champions of the drinking world) believe that a man has to hit bottom before he will get better. But they distinguish high bottom and low bottom, and some even speak of seeing bottom instead of hitting it. For one individual "hitting bottom" may be a single, deep emotional experience; for another, a spiritual experience. It is a highly relative concept. In any case, it is not hitting bottom that makes a man an alcoholic, it is hitting some kind of bottom that makes him realize it. They are diagnosable as alcoholics long before that happens, and the doctor plays his role by helping them to realize it.

Compulsion, most of all, is a matter of degree. It operates with more or less frequency and more or less force. It is a kind of fascinated thinking about alcohol or about the next drink, which takes possession of the alcoholic's mind on certain occasions, constrains him to drink even against his better judgment and his sincere determination not to. An alcoholic cannot safely take one drink. Not even of beer or of wine. It is even dangerous to prescribe medicine for him, such as cough syrups or elixirs, which have an alcoholic content. It is often after a drink or two that his compulsion is touched off and he is overwhelmed by an addictive urge to drink more.

This is not the place to discuss the moral implications of compulsive behavior, and I am far from intending that, just because one

alternative is more attractive or alluring than another, one is compelled to choose it. Human emotion, passion and concupiscence, the attraction of the sense appetites, cause conflicts in all of us. That is not sickness, unless it is the sickness of original sin. But I am speaking of a type of compulsive thinking which has reached pathological proportions, a kind of fascination with one alternative which precludes a truly realistic appraisal of the other. When this happens, the moral responsibility for the act that results is greatly diminished and sometimes eliminated.[2]

The reason why it is impractical to talk to the alcoholic about using his will-power is that his sickness consists precisely in this: he has no will-power with regard to the object of his compulsion at those times when the compulsion takes over. People do not escape the domination of a compulsion or an addiction by saying, "I won't, I won't, I won't." And we give them very poor assistance when we keep saying, "Don't, Don't, Don't." Compulsions cannot be directly overcome by will-power. They have to be forestalled or circumvented.

The test of this compulsion is not the ability to stay away from alcohol completely for a week, or a month, or a year. So often the inexperienced will say: "He is not an alcoholic. He didn't touch a drop all during Lent, and there was plenty around." The test of alcoholism is not abstinence. Thousands of recovered alcoholics never touch a drop, but they are still alcoholics, because if they drank again, they would soon be in trouble again. The test is the ability to drink regularly with true moderation. A person who can do that is not an alcoholic. If there is one thing that all the experts are unanimously agreed upon it is this: an alcoholic can never learn to drink moderately. In fact, some would make this the definition of an alcoholic and the criterion of alcoholism: — "a person who cannot learn to drink moderately no matter how hard he tries." And they would not be far wrong.

When these three are present together — excess, life problems, and compulsion — the physician need have little doubt that he is dealing with an alcoholic. It does not take a specialist to make this kind of a diagnosis. But it requires familiarity with the patient's drinking history, and familiarity with the characteristic patterns of alcoholic drinking, *i.e.*, the characteristic phases of alcoholism. The first of these, the history, can be obtained at least in part from the patient himself. The history referred to here is not a psychiatric history, looking to the underlying psychological causes of the abnormal drinking, but enough of his drinking history to divulge the tell-tale pattern of alcoholism. Perhaps this tell-tale pattern is thrice apparent without any history taking at all. One of the advantages of the general practitioner is that he often knows the family and personal history of the patient. But at least the history taking will impress the patient with the fact that when the diagnosis is made, it is made on the basis of thorough knowledge. Perhaps the time will come when some ingenious expert will devise the key questions to be asked and will put them out in convenient form for the physician's use. Frequently, however, the wife or husband or members of the patient's family are needed to supplement the patient's own account of his drinking. For if he is an alcoholic, he may have little insight, and may deceive the physician with or without deliberate intent, in important matters.

As for the second point, the characteristic phases of alcoholism have been very usefully described by Jellinek.[3] There are various more popular diagnostic aids such as the twenty question test, the thirteen steps to alcoholism, the characteristic behaviors of alcoholism, etc., which may be of help to both doctor and patient in making the diagnosis.[4]

Doctors may ask why the experts have adopted the broader definition of alcoholism and relinquished the older medical one based on the complicating diseases. The reasons are practical. First, the broader conception is now very widely accepted nationally and internationally. Uniformity of terminology is desirable. Secondly, for purposes of diagnosis and referral for long range therapy, whether the referral is to a psychiatric specialist, a medical specialist, a spiritual guide, or A.A., the crucial point is not the presence or absence of a complicating disease. The crucial point is: can this person ever learn to drink normally again? If it is judged that he cannot, then no matter where he is referred, no matter to what school of thought the specialist belongs, the practical goal of treatment will be the same: *complete abstinence for life.* No one believes that there is any hope in the present state of our knowledge, of teaching alcoholics how to drink moderately. It is agreed, of course, that most alcoholics will have to make thorough-going psychological readjustments in order to come to terms with life, and that they may need psychiatric help to do it. But even those who shrug off the drinking itself as a mere symptom of the alcoholic's underlying mental or emotional illness, and try to treat that underlying cause, can never call their treatment successful until they get rid of the symptom.

Compulsive drinking, if a symptom, is a runaway symptom, which acquires an importance of its own. People die of it. From one point of view suicide also is just a symptom of an underlying mental illness. But unless you control this symptom you have a dead patient on your hands.

One of the foremost psychiatric

[2]See *Depth Psychology, Morality and Alcoholism*, John C. Ford, S.J., Weston College Press (Weston 93, Mass.), 1951, pp. 66-76.

[3]E. M. Jellinek, *Phases in the Drinking History of Alcoholics*, Hillhouse Press, New Haven, 1946.

[4]See for example the literature provided by local information centers on alcoholism, by State sponsored programs, etc. The characteristic behaviors of alcoholism are also listed in: *Man Takes a Drink*, John C. Ford, S.J., Kenedy, New York, 1955, at pp. 90-96. For the twenty question test see *Depth Psychology, Morality and Alcoholism*, p. 49, note 116.

experts in alcoholism, Dr. Harry M. Tiebout, in a frank talk to his colleagues, declares that the reason why the psychiatrist fails so often in the treatment of alcoholics is that "he bypasses the disease and looks for causes; he ends up talking about earlier experiences and never gets close to the patient or the illness." And he states further: "Any treatment of the alcoholic must be remedial. There is no present value in getting at the causes and correcting them because the net result of such an endeavor would be to enable the person to drink normally. While such a goal may be achieved in some far-off millenium, its attainment in the immediate future is absolutely unlikely. Any therapy devoted to such a goal is admittedly unrealistic; everyone acknowledges that there is no present cure, that the only remedy is total sobriety. The person does not learn how to handle liquor, he stops using it. The goal of therapy, therefore, is to get the patient to stop taking the first drink."[5]

Courage and Tact to Communicate the Diagnosis Tellingly

Alcoholism understood in this light is a diagnosable disease, and easily diagnosable — except by the alcoholic himself. He generally does not know what alcoholism is. He cannot think of himself as an alcoholic. He cannot bring himself to believe he is one. The general practitioner or family physician is ideally situated to do a good educational job. He is on the firing line. He often knows the family and personal history. He may be the first one to see the case, and his attitude is going to make a lasting impression on the patient. Americans listen to their doctors and respect their opinions in medical matters.

I do not mean that the alcoholic will recognize himself as such the moment the doctor tells him, much less that he will immediately stop drinking. It may take time and repetition and more bouts with the bottle before he will be ready to let the idea take hold. But it is an essential part of his education about his own disease that he be told about it by a medical man who shows that he knows what he is talking about. It is essential that he be told in no uncertain terms: "You have alcoholism," or "You have developed alcoholism." (And these phrases, by the way, seem to be more effective and more acceptable than "You are an alcoholic.") It is not easy to break this hateful news. For the physician to communicate this diagnosis tellingly, he needs both courage and tact.

If the doctor has not the courage of his convictions, the patient will sense it very quickly. If he accepts alcoholism intellectually as an illness, but does not accept the alcoholic emotionally as a sick man; if he is not deeply and personally convinced that alcoholism is truly a medical problem; if he still harbors the idea that alcoholism may be an illness but it is not a "legitimate" illness; if he sets himself up as a judge and implies by his attitude: "You have an illness, but you brought it on yourself, and you deserve to do a little penance for it;" if he still thinks that though it is an illness, it is not his problem and that the situation is pretty hopeless anyway — these judgmental and defeatist attitudes will betray him and destroy his effectiveness with his patient.

A well-balanced attitude on drinking, drunkenness and alcoholism is a prerequisite if one is to give effective advice and treatment. I have noticed that priests and ministers who drink themselves sometimes feel uncomfortable, for no good reason, about dealing professionally with alcohol problems. There seems to be some vague feeling that they have disqualified themselves. Of course, if their personal use is somewhat immoderate, that is understandable as a defensive reaction. Something similar is observable at times in the case of a physician. If he drinks a little too much himself, he feels guilty and uncomfortable in dealing with these patients. If he has an unsolved drinking problem of his own, he may be very slow to make a diagnosis of alcoholism in his patient. He would be condemning himself. And in any event, the attitudes of our society are so confused and ambivalent where alcohol is concerned that it takes study and effort for anyone to acquire a well-informed, well-balanced attitude. But such an attitude is necessary for one who must have the courage to break the unpleasant news to the patient: "You have developed alcoholism."

It is not enough to be courageous. Tact is also necessary. A man's drinking habits are a peculiarly personal thing. One who has trouble with his drinking will consider this part of his life as much his own business as his sex life. If the physician is going to convince the patient he has alcoholism, he may have to prepare him for the news. The ideal is to lead the patient to diagnose himself as an alcoholic. There is a good deal of literature available now to help the alcoholic to do this. The physician may know very quickly what is wrong with the patient. He is just another alcoholic. But it may take more than one interview, and the passage of time, and some serious reading and study on the part of the patient, before the moment arrives for that straightforward pronouncement: "You have developed alcoholism. It is a progressive and incurable disease. It can be arrested only by complete abstinence. In order to arrest it, you will need continued help."

Resources and Referrals

There are a good many resources available to the general practitioner who wishes to refer a patient for further help. The best of these for the majority of patients, and the most universally available, is Alcoholics Anonymous, as mentioned previously. The physician should know this program and should be personally acquainted with some successful members of A.A., so that when a patient is willing to accept help from them, the doctor will not merely "send him to A.A." but will

[5] Excerpts from a paper presented to the National States Conference on Alcoholism in October, 1955, reprinted in *The A.A. Grapevine*, 13 (Sept., 1956), pp. 5-10.

contact the right people in A.A. to help this particular patient.

There are thousands of A.A. groups throughout the country, at least one in every sizable town. They are usually listed in the telephone directory. If not, the address of the nearest group can be obtained from their national headquarters.[6] If there is no time for that, a telephone call to the local police station will usually elicit the desired information. Members of A.A. are ready to help *if the alcoholic himself* is asking for their help.

Many patients will not hear of going to A.A. when it is first proposed to them. Either they are still unconvinced and are determined to learn how to drink without getting into trouble, or, if they have reached the point where they admit they have alcoholism and can never drink again, they think they can manage this business of sobriety by themselves. Often one can but let them try it; but the door should be left open for a future change of mind and heart.

I do not mean to give the impression that A.A. is the only thing there is, or that for every alcoholic it is the best solution. Some alcoholics are badly in need of specialized psychiatric care, or the care of a medical specialist in alcoholism. But this is not true of the majority. The majority, besides, are in no position to pay for such care. It is easier, however, to get some patients to go to a psychiatric or medical specialist than to go to A.A. The general practitioner will know, of course, or be able to find out the right specialist in alcoholism for his patient.

One of the difficulties that plagues both specialists and generalists is the refusal of most general hospitals to admit acute alcoholics for treatment. Feldman and Zucker have this to say: "The ideal place for treatment of the acutely alcoholic patient is the hospital, and every effort should be made to convince both the patient and the hospital of the wisdom of this arrangement. It is surprising how little difficulty most acutely alcoholic patients cause in hospitals, a fact repeatedly confirmed by those hospitals courageous enough to admit this type of patient on the same basis as any other. It seems as though merely treating these people as any other sick person somehow makes them more tractable and cooperative. Occasionally they become model patients. Hospitalization in open or general hospitals is not to be recommended if the patient is actively against any treatment or if force must be used."[7]

Some general hospitals have followed the lead of St. Thomas Hospital, in Akron, Ohio, where Sister Ignatia first introduced the plan, and have instituted a five-day program of treatment in conjunction with Alcoholics Anonymous. They have had remarkable success in these institutions and have not found the alcoholic patients more difficult to handle than other types of patients they receive.

[6]Alcoholics Anonymous, P. O. Box 459, Grand Central Annex, New York 17, N. Y.

[7]*Loc. cit.*, p. 896.

The families of alcoholics have put up with so much that they are often thoroughly disorganized, and it is often the wife of the alcoholic who seeks the physician's help. The Al-Anon Family Groups, Inc. — an offshot of A.A. but not directly connected with it — was formed to help the families, especially the wives, of alcoholics to meet their problem wisely and effectively. There are now hundreds of these groups throughout the country.[8]

If alcoholism is a sickness of body, mind, and soul, many alcoholics, if not all of them, need spiritual help. There are cases where the doctor can help them to get it. The physician who, in accordance with the highest ideals of the profession, considers himself not merely a scientist and technician but a healer, with the total welfare of his patient at heart, can often put a confused alcoholic on the right track. This is especially true if there are clergymen available (and the number is steadily growing) who have an understanding of alcohol problems and take a special interest in them.

The general practitioner can also make good use of the services offered by the National Committee on Alcoholism.[9] This is the national clearing house for information on developments and activities in the field of alcoholism. It disseminates the latest scientific findings in this field, and also guides and stimulates the establishment of community programs on alcoholism. Literature is available, including literature for physicians, from the national headquarters. The Committee has about fifty local affiliated committees, operating programs of information, organization, education and guidance. Some of them are in a position to guide the individual alcoholic, through experienced counsellors, to the help best suited to him. They can also inform the doctor of all the local treatment facilities for handling alcoholics.

One of the most encouraging developments from the medical point of view is the establishment of State programs to deal with alcoholism. There is a great variety and number of such programs throughout the United States. Some of them operate special hospitals and out-patient clinics with a staff trained to carry on the long range therapy of the alcoholic. Information about a State program, if there is one, and about all the local treatment facilities for alcoholics, can be obtained by contacting the State Health Department.

Finally, many of the local medical societies have now organized special committees on alcoholism. These committees know the local resources and will guide the physician in referring his patients to the best sources of continuing help.

In writing the above observations on the role of the general practitioner in alcoholism, I have

[8]The Al-Anon Family Groups, Inc., P. O. Box 1475, Grand Central Annex New York 17, N. Y. A very useful book for the family of the alcoholic is: *Primer on Alcoholism*, Marty Mann, Rinehart and Co., New York, 1950.

[9]The National Committee on Alcoholism, Suite 454, New York Academy of Medicine Building, 2 E. 103 St., New York 29, N. Y.

said very little about the moral, spiritual, and religious aspect of these problems. This is not because I underestimate them. In the last analysis, the excessive drinking of alcohol is a problem of human behavior. Like every such problem, it has theological implications, illustrating vividly the mysterious interplay of free will and divine grace within the human soul. The grace of God is all-important to the alcoholic. The physician by his skill, his understanding, his tact and his compassion can remove the obstacles to that grace. He can be compassionate without being mawkish. He can be tactful without pussyfooting. He can be forthright without crushing.

But if alcoholism is a triple sickness, it has its medical side, and the general practitioner has a cooperative medical role to play. If he knows the facts about alcoholism, if he has the knowledge, the courage and the tact to make a forthright diagnosis, if he knows the available resources, he can guide these patients to recovery. Recovery means contented sobriety. The situation is no longer hopeless. The recoveries will soon be numbered in hundreds of thousands.

Readers will be glad to know that Father John C. Ford, S.J., was named this year's recipient of the Cardinal Spellman Award, for outstanding achievement in the field of sacred theology. In addition to his doctorate in sacred theology, Father Ford has received the degree of bachelor of laws. He has taught jurisprudence and domestic relations and is an annual guest lecturer at the Yale School of Alcohol Studies. He has been a member of the Governor's Commission on Alcoholism in Massachusetts. His writings and lectures, besides covering moral problems of alcoholism, have been concerned with the morality of obliteration bombing, and other moral, medico-moral and legal problems.

THE LINACRE QUARTERLY congratulates Father Ford on receiving this notable Award, with the wish that his work will continue with God's choicest blessings.

FEDERATION EXECUTIVE BOARD MEETING SCHEDULED

The Executive Board of the Federation of Catholic Physicians' Guilds will meet Dec. 8-9, 1956, beginning at 9:30 a.m., Hotel Statler, Cleveland, Ohio.

The officers of the Federation and one delegate from each active constituent Guild constituting the Board will conduct business.