Appendix D

CLINICAL TEACHING

The goals for clinical teaching were developed by a special task force, comprised of representatives of each of the clinical clerkships. These goals were set forth in the task force's report, entitled "toward a Perturbation of the Clinical curriculum on Alcoholism (Appendix A) With hindsight, the goals presented in that document are now seen as too ambitious in light of the structure and general goals of undergraduate training.

It would be appropriate to scale down expectations to three objectives: (1) to recognize non-normative drinking; (2) to affect consultation with an alcohol specialist with the goal of making the differential diagnosis and developing treatment and referral recommendation; and (3) to work with and support consultants in effecting a referral for treatment.

Beyond establishing goals for undergraduate clinical teaching, Project Cork also embarked upon several discrete projects to enhance clinical teaching. These include the following.

- **Weekend Program**
  A three-day, residential educational and diagnostic program for those arrested for driving under the influence; students participated during their psychiatry clerkship.

- **Bridge Program**
  A month-long clinical alcohol experience for medical students prior to their entrance into medical school.

- **Interviewing Tutorial**
  An individual session using simulated patients to teach interviewing skills, conducted during the Community and Family Medicine clerkship.

- **Use of Recovering Alcoholics in Teaching Programs**.
  Use in a number of settings to introduce students to alcohol treatment programs and AA.

The WEEKEND PROGRAM

The Weekend Impaired Driver Intervention Program (WIDIP) was initiated by Project Cork in 1984, through a contract with the State of New Hampshire. The Program is an educational and assessment program for individuals who have been convicted of DWI. It is designed as an intensive residential program which begins on a Friday afternoon and concludes on Sunday afternoon. Program time is divided between lectures, films and small group discussions. The Weekend staff includes a medical director, counselors/group leaders, medical students and administrative personnel.

The Weekend program provides a unique site for clinical teaching. The program provides a setting in which students are exposed to the process of making a differential diagnosis between no alcohol problem, alcohol abuse, and chronic alcoholism. Medial students can observe the early stages of developing alcohol dependence prior to the onset of major medical complication requiring hospitalization, the usual point at which a medical student would have clinical contact. Medical students participate in the Weekend Program as part of the psychiatry clerkship.

The Program was adapted and modeled after the Weekend Intervention Program conducted at Wright State University School of Medicine, Dayton OH, directed by Harvey A. Siegal, Ph.D

PROGRAM DESCRIPTION

The Weekend Program begins on a Friday at 4:00 pm with intake and registration, and continues through Sunday at 4 pm. It involves 28 hours of direct client contact. This includes medical screening, individual sessions at registration and at the completion of the program, plus small group discussion/group therapy, educational lectures and films. In addition to a medical director, staff consists of trained, experience alcohol clinicians who are assigned individual clients and conduct small groups, which have 6:1 client/staff ratio. The program in conducted at the Dartmouth Medical Center. Patients eat in the hospital cafeteria, and board is arranged at a local country inn with transportation to and from the Inn provided by the program.

Enrollment. Referrals to the Weekend Program are made by courts located within a designated catchment area. (While initially established to serve the drinking driver population, the program has also accepted referrals of others for whom an assessment is required. These have included college students who were involved in an alcohol-related incident, and also individuals referred by area clinicians). The $295 cost, set by the state of New Hampshire, is borne by the client. (For non-court referrals, client's health insurance is billed.) Prospective clients are provided informational packages and also requested to supply a brief medical history prior to attending the Weekend. In the packet an invitation is extended to family members to attend both a special group for family members/close friends which occurs during registration and to join in an

educational film session and the individual exit interview at the completion of the weekend. More extensive family participation is possible by arrangement.

Intake. The intake and registration includes the following: a brief, approximately half-hour medical examination, including an alcohol use history, to ascertain medical status and the ability to participate in the program, as well as to ascertain relevant history; self-administered questionnaires, and a structured one half-hour interview (Mortimer-Filkins) with the client's counselor/group leader.

Friday Evening through Sunday. The participates are involved in five 2-hour small group sessions, five educational lectures, and 5 films. Clinical supervision of counselors is provided by the medical director, by a peer supervision process, with consultation available around group issues, as well as by a physician on call. During the Weekend there are several occasions during which the status of each client is reviewed. In the small group sessions, which occur 'Sunday morning, the clients are asked to shared their self-assessments with respect to the presence of an alcohol problem, in light of the factual information presented and the information which has been shared among the group members; the counselors then present the program's assessment, including any "generic" treatment recommendations. (Specifics of any referrals, the name of the agency and, when possible, a specific clinician name, are presented at the exit interview. The program uses the DSM-IV diagnostic criteria and has developed protocols outlining the appropriate interventions for those meeting criteria for either dependence, abuse, or those not meeting diagnostic criteria for abuse or dependence.

Throughout the weekend effort is placed on discussing alcohol use as a medical issue, a health concern. Alcohol is described as the most potent, widely self-prescribed agent. Attention is also directed to the fact that negative consequences are not limited to those with alcohol abuse or dependence. For those without a formal alcohol diagnosis, efforts are made to identify high risk alcohol use patterns. For example, beyond drinking and driving, as either a driver or passenger, there may be other activities where alcohol use may be risky, or alcohol use may interact with prescribed medications.

At completion. In the exit interviews, involving the physician, client, family member if available, and the counselor/group leader, the diagnostic assessment is presented as well as treatment recommendations and the rationale. If a referral is made, efforts are made to specify the worker in the agency and provide a specific appointment time. In all instance every effort is made to promote compliance. On occasion the medical director may contact the client in the days following the Program, to encourage compliance with the treatment recommendations. For court referred clients, individuals have the opportunity to counter-sign the required form sent to the court. In addition, a release of information is requested to allow the program to send a letter to the client's family physician. This letter describes the involvement in the Weekend Program, any medical concerns identified, and positive and negative findings with respect to alcohol use. These letters were drafted by the medical students and reviewed by the medical director. At the closure of the Program the clients also completed other mandated forms, a knowledge test, as well as an evaluation of the weekend experience.

Two months Post-Weekend. As set forth by the State regulations and with the requisite client release of information, the Program contacts the agency to which a referral was made, and ascertains compliance and follow-through. Approximately 50-80% of the persons in each weekend are referred for treatment or further follow-up.

Schedule: Dartmouth-Hitchcock Weekend Program

Prior to Weekend. Meeting with the Medical Director, to review the history and physical exam format, the weekend schedule, and expectations for students participating in Weekend.

Day/Time	Activity	Medical Students
FRIDAY		
3:45 - 4:30 pm		Introduction to group process with staff group therapist
4:00 - 6:00	Registration Individual with counselor Physical Exam Completion of paper work Family Session	4:30 Meet with Medical Director. Begin physical exams & alcohol history
6:00	DINNER	With counselors
7:00 –7 :30	Welcome-Overview Medical Director	
7:30 – 8:00	Lecture I: *Drinking, Driving, DWI, Attitudes*	7:30 – 8:15 Meet with Medical Director
8:00 – 8:30	Film: *Until I Get Caught*	8:15 Meet with counselors
8:30 – 10:00	Small Group I	Participate as small group co-leader with debrief after
SATURDAY		
7:00 am	Breakfast for clients at Inn	
7:45	Bus Pickup	

8:00 - 8:50	Lecture II *Alcohol the Drug*	Attend lecture
9:00 - 10:00	Film: *I'll Quit Tomorrow, Part I and II*	and Film
10:00 - 12:00	Small Group II	Co-lead small group
12:00 - 12:45	Break with Physical Exercise	Take walk with clients
1:00 - 1:30	LUNCH	Optional lunch with Medical Director & Counselors
1:30 – 2:30	Lecture III *Alcoholism the Disease*	Attend lecture
2:45 – 4:45	Small Group III	Participate as small group co-leaders
4:45 – 5:15	Break	
5:15 – 6:00	Film *Chalk Talk*	Meet with group therapist
6:00 – 6:45	DINNER	
6:45 – 7:30	Lecture IV *Alcoholism and the Family*	Attend lecture
7:30 – 8:00	Film *Soft is the Heart of a Child*	Attend film
8:00 –10:00	Small Group IV	Co-lead small group
10:00 pm	Bus Pickup	

SUNDAY

7:00 AM	Breakfast for clients at Inn	
7:45	Bus Pickup	
8:00 – 8:30	Film *I'll Quit Tomorrow* Part III	Attend film
8:30 – 9:00	Lecture V *Introduction to Treatment*	Meet with Medical Director
9:00 – 11:00	Small Group V	Co-lead small group
11:00 – Noon	Attend AA meeting or Discussion Group	
12:00 – 1:00	Large Group Meeting	
1:00 – 1:30	LUNCH	
1:30 – 3:30	Individual Exit Interviews "Film Festival" *Days of Wine and Roses* *If You Loved Me* *Combacker,* *The Sorrows of Gin*	Participate in exit interviews
3:30 – 4:00	Knowledge Post-test Program Evaluation Form Large Group Wrap-Up	

4:00 – 5:00	Staff Debriefing	Attend meeting
Monday:		Debriefing with Medical Director, Submit letters for primary care providers of clients in student's small group

Report on a Month-long Clinical Experience Prior to Entering Medical School: The Bridge Program

Jean Kinney, MSW
Trevor R.P. Price, M.D.
Bernard J. Bergen

(Presented by Professor Bergen at the National Conference on Medical Education in Alcohol and Drug Abuse, November 1980, Washington DC.)

Dartmouth Medical School has undertaken a major curriculum experiment around alcohol and alcoholism, through a grant from Operation Cork. This paper focuses on one component of that effort, a special clinical elective available to students prior to their entering medical school. It is offered as a four-week work-study program, for which the interns receive a stipend.

The purpose of the intern program is not to develop skills, but to provide an opportunity to learn what being alcohol dependent is like, wand what being a helping person is like. Follow-ing a two-day orientation, the interns, assigned an alcohol counselor as a supervisor, work an eight-hour day and are exposed to and involved with the full range of agency services. To complement this clinical contact, the interns meet twice weekly for a one and a half-hour sessions in a loosely structured seminar which focuses on the discussion of issues raised by their work experience. This seminar is led by the authors of this report.

Approximately 25% of the class applies for this program. The selection of six interns is made without access to student files. With very limited information, we nonetheless attempt to get as heterogeneous a group as is possible.

The major impetus for this program came from Drs. Bergen and Price and arose for their earlier involvement in elective seminars of death and dying, offered to second-year medical students.

To the surprise of Bergen and Price, these seminars showed the efficacy of raising the prob-lems related to "difficult" patients with students who had not yet had any clinical experience. Two things struck them. First, issues about the doctor-patient relationship that faculty often regard casually as "philosophically abstract" were treated by students as alive and vivid and not abstract at all Students were intensely preoccupied with the question of defining their professional role. Second, part of this intensity seemed ground in developmental issues stu-dents were working through in their own lives, especially issues concerning authority and control over others.

These experiences piqued the curiosity of Bergen and Price about the impact which a very early clinical experience might have. However, it should be noted that the proposition was not without its detractors. The major concern was that entering students are unprepared for clin-ical

involvement and too likely to be "distracted" from the more important task before them, that of mastering the basic biomedical sciences.

Aside from any impact this four-week experience has had on the interns is has provided the larger project with solid dividends. The mere fact that each incoming student is invited to apply announces that alcohol and alcohol issues is a special concern.

Secondly, the interns achieved a heightened visibility with their classmates and are catapulted into the role of the class' alcohol experts.

By the end of a month, the interns have developed a certain comfort and sense of mastery in the alcohol area. Via the grapevine we hear of them commenting to a peer on his seeming over-involvement with alcohol, or hear of their willingness to draw upon their experience in class discussion. One of the least anticipated impacts has been the interns influence upon faculty. One faculty member wryly observed that having them in the lecture hall is like having the Project looking over our shoulder. The interns too have objected in class to inappropriate "drunk jokes."

While the formal evaluation is not completed and we are not about to make any definitive claims, we are reasonably certain this approach is not having a negative impact. We also believe we have gleaned several instructive insights about the educational task. We now turn to two major issues.

1) The extent to which students' perceptions of the physician's role influences their response to alcoholics; and
2) The extent to which the students' own developmental issues mold their response to the alcoholic patient.

In the process of discussing these two issues we also plan to challenge some of the assumptions and approaches which seem to have particular currency in the alcohol field. We suggest that if our observations are accurate some of these approach may be, if not counter productive, at best of little benefits.

Issue One. Physician Role. We have been profoundly struck by how deeply rooted and narrowly scribed are the interns' perceptions of the physician's role. They come to their first seminar after two days of clinical contact. At that first session they are already sounding like battle-weary clinical veterans. As they talk about how they would respond to alcoholics, several years hence, they draw upon all the standard lines. They mention the inordinate demands of the physicians time, they need for efficiency and cost effectiveness, the imperative imposed on the physician to devote himself to those who "really" need help. To their minds the physician's proper function is to ferret out the cause of disease, using all the available technology, and administer cures, preferably as expeditiously as possible. The physician is a combination of scientific sleuth, and warrior doing battle with disease.

Despite the fact that the first tuition payment is yet to come, they also have an elaborate apologia for this stance. Their idealism is seen as being exercise if they conscientiously and wisely

expend themselves, devoting attention to the "really sick." The "really sick" are operationally defined as those who will respond quickly.

In the course of the seminar the point was gently but repeatedly made that this view of the physician's role may lead to disaster. It was suggested it may lead to poor patient care and be a source of frustration for them. This was quite unsettling for virtually all to hear. That patients with chronic disease may comprise as much as 80% of a practice was a revelation.

A related question was also raised, that is how an individual's motives for becoming a phys-ician may color the response to clinical work and dictate which is expected from clinical interactions. It was suggested if one's self-esteem, sense of competence, and personal satisfy-action are tied to how one's patients do, one may be unhappy with much of medicine. The possibility was posed that how one's patients do is not only not the last word in defining the practice of good medicine, it may be wholly irrelevant. This was highly provocative, but an issue that student saw as very important, not only in some distant future, but important in their status as students.

There has been considerable discussion within the alcohol field about the "bad" attitudes which physicians and students have directed specifically toward alcoholics. These "bad" views are seen as rooted in a moral rather than a medical perspective, or as rooted in inadequate training with alcohol problems. Accordingly, much of the alcohol education effort has been directed toward providing corrective experiences to promote "good" attitudes. We trot students to AA. We try to put articulate attractive recovering alcoholics on display. We may do all of this and accomplish nothing, because the problem, in fact, is of a different order. Our experience shows that students come in to school with all the predictable expected biases or "bad" attitudes, and that these are changed with remarkably little effort.

In the interviews conducted with them before they began working, they all saw alcoholics in one way or another as perpetual and doomed "losers" who can never make it through life without a crutch, as opposed to "winners" who stand on their own two feet, handling every-thing that life throws at them which pulling themselves up by their own bootstraps.

Nevertheless, before the first week of work is ended, the students come to like their alcoholic patients. They believe that rehabilitation is possible and admire and root for the alcoholic in his struggles to recover. However, these "good" attitudes seem to have little impact on patent care. In light of students' views of medicine the alcoholic is simply irrelevant. The kind of care the alcoholic requires and responds to is seen as beyond the scope of the physician's primary mission. They see the physician who would be involved with alcoholics as deviant, as one who has gone out of his way to do more than could reasonably be expected.

The task is not to purge students of their moralistic approaches to alcoholics who have been uniquely and unfairly singled out. The task is not to convince students that alcoholics are really nice folks in disguise and therefore worthy of their attention. The task rather is to convince students that that physician's caring functions are as central and in many case more central than his curing functions.

To accomplish this requires several things. One is that medial education cease approaching the alcoholic as a special case outside the mainstream, The alcoholic, far from being unique, is representative and prototypical of the type of patient that will confront physicians most frequently. The only distinguishing characteristics of the alcoholic but one which further recommends him or her for teaching purposes is that with proper treatment and management he or she can be restored to better levels of functioning than most patients with chronic disease.

This approach, we believe, also provides the alcohol field with a desperately needed base for collaboration with other medical school faculty. All too often the alcohol field has been unwilling to define common ground. Too often we declare the alcoholic unique, claim the skills required for treating alcoholics are highly specialized and particular and at great lengths describe the failures of others to provide care. The only choice this affords the medical community is either to confess the error of its ways and be redeemed by becoming an alcohol expert or steer a course away from the entire problem.

Secondly, faculty need to be prepared to help students translate or reformulate the models of alcoholism provided the students by their patients and the alcohol treatment personnel. Both patients and staff are eager to teach the students that alcoholism is a disease. But the frame-work and language they call upon to do so are inadequate to the task. Some of the seemingly more superficial models, e.g. alcoholism as an allergy, the students basically ignore and/or good naturedly chalk it up to a layperson's misunderstanding. What is more difficult for students is that the symptomatology of alcoholism is more frequently described by what are essentially moral labels. Patients and counselors alike describe the phenomena of the alcoholics' behavior in terms of "lying", "manipulation," "deceit, "conning." The educator is required to provide an alternative framework for viewing these patient behaviors. Whether a patient is "lying" or whether the patients is "unable to faithfully self-report events" is not an insignificant distinction. There is a film for physician education recently released entitled, "Doctor, you've been lied to." An alternative title we would suggest is "Doctor, you've missed the truth."

We will note, however, that one commonly confessed faculty tactic is probably ill-advised, that is that "even if one doesn't believe alcoholism is a disease, it's important to tell the student that it is." The students we encountered weren't sufficiently reverent to accept such a statement on faith without asking why, or countering with a "but."

Issue Two. Developmental Factors. We now turn to the impact of the students' own development issues on their response to alcoholic patients. These differences become quite striking, if we compare and contrast two different groups of interns. Despite out attempt at a random selection process, groups in succeeding years were quite different. The first of these might be most easily described as "more adult." They were coping with marriages — present or pending — parenthood, career changes, and were living independently. The following year's group were all single, basically members of their parent's family, and for the most part their experience were limited to the typical college career. The response of these two groups to the clinical material was very different.

The first group became deeply and personally engaged in the experience. As they came to know their clients, they agonized over the meaning of being an alcoholic. They struggled over models of disease, etiology, and the issue of willpower. They argued about the limits of freedom and control. By the end of the month there was a very conscious and strong identification with the alcoholic patients. The patients were not "the other." They came to speak of admiring there patients, and the "gustiness" it takes to enter treatment and to try to change oneself. They even spoke of being envious of their patient, for their having AA. One member was quite unhappy and perturbed by the idea of closed AA meetings, because to him AA was obviously something that could benefit anyone.

While the second group similarly developed positive attitudes toward their patients, they nonetheless seemed distant and personally untouched by them. They were more like spectators — fascinated, curious, interested — but nonetheless the alcoholic remained distant and alien. One can only speculate if the experience may be assimilated at some time in the future. Generally, any attempts to encourage these students to wrestle with issues of the physician's role or their perceived relationship with alcoholics were unsuccessful. For most part, this did not arise out of defensiveness or resistance. Rather, as one student commented, "we aren't there yet, we'll have to wait and discover it for ourselves." During their work they did develop a certain amount of empathy for the alcoholic which helped them past any initial derogatory and derisive attitudes. However, their relatively sheltered, successful, well-orchestrated lives did not give them a basis for identification with the alcoholic. These students were just beginning to discover that perhaps it was a myth that they had perfect control over their destinies. As one of the seminar leaders noted, "At the very least someone has to have had one sad love affair to provide a basis for grappling with these topics."

Given these two very different responses we have come to think in terms of students being developmentally "ripe," to deal with and reconsider issues related to clinical care. For those students who are "ripe" to confront themselves, we would see the alcoholic patient as being particularly provocative. The alcoholic embodies a number of characteristics which individually are problematic and in combination are confusing and overwhelming. The alcoholic does not readily comply with the patient role, his presentation is often seen by the clinician as manipulative and deceitful, the disease is without a known cause or cure. The alcoholic patient forces the student to confront the nature of the physician's role, its limits, and to cope with that outside of his control.

How students fare in this encounter, we see as, in large measure, being dependent upon the support provided to them — to experience, explore, and articulate the dilemmas posed. The seminar sessions seemed to be invaluable for this. In the absence of the time it provided to discuss freely what was occurring, we suspect that the students' "negative" attitudes would have been solidified. We emphasize "freely." The alcohol counselors and other alcohol personnel were perceived as dedicated, hard-working, concerned and were quite respected. At the same time they were seen as having either pat answers and/or magical insights because they seemed not to really appreciate what was problematic for the students. In the course of the seminars, it became incumbent upon the faculty to suggest possible parallels both between alcoholism and other medical problems, but also the common elements of a counselor and physician roles.

INTERVIEWING TUTORIAL: SIMULATED PATIENT

Background. Within the Primary Care-Family Medicine Clerkship, an interviewing tutorial was conducted using simulated patients. This was originally conceived as a component of the evaluation effort, a procedure to evaluate student's abilities to interact therapeutically with a patient presumed to have a problem with alcohol use. However, the potency of the exercise as a teaching device, in combination with inadequate prepar-ation of the alcohol counselors to rate the students' performances, led to its continuation purely as a component of the clinical teaching effort.

Format. A cadre of four recovering alcoholics was recruited to portray active alcoholics in an ambulatory encounter with a primary care physician. The format entailed two stu-dents per session. Conducted in the evening, the simulated patient, two students and faculty member met for dinner in the hospital cafeteria. Afterward, the two students, in turn, interviewed the simulated patients. The scenario for the interview was established by the alcohol counselor and simulated patient. The students were then given the outlines of the presenting problem, always with the presumption that an alcohol problem was suspected. Thus, the task of the student was to simultaneously deal with the patient's chief complaint/presenting problems and explore alcohol use. The interviews were videotaped, with counselor, faculty member and other student present in the room. Each interview was from ten to fifteen minutes. At the completion of the interviews the videotape was viewed and critiqued by students, counselor, faculty and simulated patient together. These discussions typically dealt with two aspects. One was the interview content, i.e., what essentials of the data base were or were not elicited. The other focus was on process, i.e. how students facilitated or hindered getting the essential information, the student's and patient's emotional responses at various points in interaction, and patient resistance and physician strategies.

Comments. The students frequently noted after the tutorial that they had had no prior comparable instruction on interviewing. They generally rated the sessions very positive-ly, and saw them as being valuable. Several elements are seen as having been key to the structure: the casual encounter (meal) prior to the exercise seemed to set a tone of infor-mality, which carried through the interview. Of note is that this setting did not give immediate clues to status, i.e. who was faculty, or counselor, or recovering alcoholic. In respect to dealing with alcohol problems, faculty became acutely aware of the need to help students recognize "process" and the nature of the physician-patient interactions as important clinical data.

There is a widespread belief among those involved with medial student and physician education around alcoholism that exposure to recovering alcoholics and AA is essential. This contact is seen as a mechanism for introducing attitude change, as well as a means of challenging the students' perspectives that alcoholism is unresponsive to intervention. However, aside from an issue of *About AA… a newsletter for professional men and women* published by the General Service Board of AA, there have been no guidelines or descriptions published on organizing educational effort.

Within Project Cork, Dartmouth Medical School has utilized recovering alcoholics in classroom teaching in a variety of ways which are described below. Prior to the Cork project, Dartmouth had required and has continued to require, attendance at an AA meeting as part of the undergraduate medical school curriculum.

RECOVERING ALCOHOLICS IN CLASSROOM TEACHING

Rationale and formats. Ideally , the first alcoholic to whom the medical student is introduced professionally has been successfully treated and is in recovery. For teaching purposes, the recovering alcoholic has many advantages over the active alcoholic or alcoholic newly admitted for treatment. The recovering alcoholic supplies first-hand evidence that alcoholism can be successfully treated. This provides an important reference point for considering the disease process and an important counterbalance to the more frequently occurring exposures to active alcoholism during medical training and before. The recovering alcoholic can speak both to the onset and course of the disease as well as treatment and recovery process. Even if one wishes to demonstrate the behavioral manifestations of the active alcoholic, the recovering individual can simulate the behaviors, and upon stepping out of the role can comment upon and reflect upon the phenomena depicted.

Within Project Cork, recovering alcoholics have been used in a variety of ways: as panel members, as part of an orientation prior to student's involvement in alcohol treatment program; as "patients" to be interviewed by small groups during the first year psychiatry course; as simulated patients during the primary care clerkship, and in case presentations in correlation clinics.

Organizational Issues

Selection of volunteers.. With the help of alcoholism counselors, clinicians, and from contacts with members of AA, Project Cork has assembled a roster of recovering alcoholics who are willing to participate in medical school teaching. A diversity of socioeconomic backgrounds, ages, and drinking history are among the criteria for selection of the volunteers. The educators seek articulate persons who can compare and contrast their own experiences with those of others, and who are sympathetic to the involvement of professionals in alcohol treatment. At least two years of sobriety is desirable. Persons with unusually dogmatic views or who have an axe to grind with physicians are rarely useful.

Briefing of volunteers. It has been important to explain to volunteers the format and goals for the specific session, what will and will not be expected of them, the general educational goals, and the place of the particular session within the total curriculum. "Coaching" in the sense of concrete suggestions as to the type of information which would be of interest to students and that which may be confusing, is provided. A reminder to the volunteers is in order, that they may have to "translate" AA or alcoholism treatment terminology. Volunteers also welcome feedback from faculty following the session and often have good suggestions for future sessions.

Preparation of faculty. Faculty need to be informed about what a volunteer is or is not prepared to discuss. Faculty are open to suggestions for structuring the interview. The small group leaders in the first year psychiatry course were provided with a suggested list of questions:

(1) What were the early symptoms form the alcoholic's perspective?
What were the early symptoms that family and friends noticed?

(2) What prompted treatment?

(3) What did treatment consist of?

(4) Alcoholics often report having the self-realization that "something's wrong" prior to their becoming aware that the "something" is alcoholism. Was that the individual's experience? If so, what did the person think "the problem" was?

(5) Was the person seen by a physician while an active alcoholic? If so, was the alcohol use discussed? Does the individual recall trying to hide the alcohol problem from the physician? Is there anything the physician could have done which might have prompted earlier treatment?

(6) As a recovering alcoholic, what response has this evoked from others?

(7) What was the process of getting sober like? Were there any particularly difficult times?

We've found that the most constructive approach has been for the group to engage the recovering alcoholic as a "consultant" in studying the illness. A "diagnostic interview" approach is rarely helpful and often counter-productive. In fact, all that's really added in most such situations is to get the students talking with the recovering individuals— the information exchange then usually takes care of itself.

ALCOHOLICS ANONYMOUS

Within teaching programs, if one uses recovering alcoholics or clinical rotations in an alcohol treatment program, the students inevitably have contact with members of AA and some exposure to its philosophy and program. AA's name is widely known in the general culture; this is a source of information and misinformation. However, such exposures cannot be assumed to be substitutes for systematic exposure and introduction to AA

A variety of formats can be used in medical education to introduce students to AA: most involve attending/observing a meeting of AA. Dartmouth Medical School students attend two meetings in the community, one in connection with the first-year Psychiatry course and another during

their clerkships. In larger cities it is not uncommon for AA members to come to the medical school and put on a "demonstration meeting." In Cork's experience, what appears to be critical to the success of this exposure is the briefing of the students prior to attending an AA meeting and debriefing afterward, to allow them to process the experience.

The reasons for requiring students to attend AA should be made explicit to the students. Among the goals are understanding how AA work both in terms of mechanics of affiliation, as well as therapeutic process, and becoming familiar with a widely used modality of alcohol treatment. The briefing and debriefing may involve alcoholism treatment personnel, and should also involve a physician.

Student Briefing. Topics to be included in the introductory session conducted prior to their going to an AA meeting are a brief review of the history of the Fellowship, how it is structured, where a meeting fits in the AA program, and philosophy as a whole. While it is useful to ask students to consider their feelings in advance about walking into an AA meeting without any introduction, we suggest that students in attending meetings introduce themselves as medical students who want to observe, and that they should, in fact, be observers. Any attempts at disguising their student status usually fail; members generally welcome students, and will seek them out for informal discussion following a meeting. The students should not take books, nor have paper and pencils for note-taking. The tradition of anonymity should be briefly explained and students asked to respect it. They may be alerted as well to possible critical views of physicians. Most specific questions at this stage about AA beliefs should be turned back to the students as foci for their observations, rather than answered by the briefing faculty. Such questions are better answered by the students themselves from their own experience at the debriefing session.

Student Debriefings. In this session it is important to allow students to discuss their experience of the meetings, particularly what surprised them — often the diversity of age, and socioeconomic backgrounds — and what troubled or confused them. Jargon may need to be translated and the use of humor explored. Students should have a chance to discuss what it felt like to be there and their thoughts are about what was transpiring at the meeting which made the experience therapeutic. Other useful topics include sharing of observations about the spiritual/religious statements or behavior, expressed attitudes toward physicians and the nature of authority within the self-help community.

Selecting AA Meetings Any area will have a large number of AA meetings from which to choose. A discussion meeting is more information that a speaker or "step meeting" because it allows students to hear more views and observe more interactions in a single meeting. We believe it's most effective, however, to have a group of students attend a variety of meetings, and pool their experiences. Inasmuch as every AA meeting has its regular members, it is suggested the grapevine be used to inform groups that students will be present and to elicit feedback. AA groups typically welcome any observers, but should not be expected to absorb numbers that will distort their group process. Cork made efforts to limit the number attending a particular meeting to limit to two students.

Another variant upon students' attendance at AA is to match each student with an "AA" sponsor who arranges to take the student to the meeting and chat afterwards. However, this required

considerably more administrative effort, and did not seem to further enhance what was already a positive experience. In the Philadelphia area, the AA Intergroup Association's Subcommittee on Cooperation with the Professional Community had developed a mechanism for "sponsorship" through which individual AA members introduce professionals to AA. This Intergroup program has been used successfully by four medical schools in the Philadelphia area to introduce their students to AA.

Responses to AA. When this procedure of briefings and debriefings is followed, the students responded positively. The student evaluations at the close of the psychiatry clerkship have consistently given the AA meeting the highest ratings. In general, students are very favorably impressed by the warm, supportive atmosphere of the meeting, surprised by the level of "insight" and commitment to change, and awed by the heroic effort required to achieve sobriety. The diversity of backgrounds of the members is usually unexpected, as well as the ability of such a heterogeneous group to interact with the level of intimacy which is observed. The single most disturbing feature is the levels of coffee consumed, and the number of smokers present.

ALCOHOL TREATMENT PROGRAMS

Alcohol clinicians and treatment program staff are usually eager to be involved in medical student education program in almost any capacity, from hosting a tour of their facility, to incorporating students for a clinical training experience. Be prepared, how-ever, for concerns about confidentiality and/or simple disruption in programs unaccustomed to dealing with trainees. There are those who have become clinicians in the alcohol field in response to their own personal alcohol experiences. For many of them the physician's role in and efforts around alcohol treatment may be emotionally charged topics. The student may be the recipient of generalized anger towards physicians or alternatively the target/symbol of unrealistic expectations and hopes. Alcohol treatment staff, although good clinicians, may have had little experience and no formal training as supervisors. Also, they will be largely unfamiliar with the content, organization, or structure of medical education. Alcohol treatment staff commonly have difficulty pro-viding concrete useful feedback to students. The alcohol treatment staff's expectations of what a physician's skills should be and the nature of his or her relationship is likely to be incongruent with that of faculty.

Suggestions for organizing alcohol treatment experience

- Orient treatment program staffs to your goals, explore their personal goals, and set forth suggestions for staff around supervision.

- Do not expect treatment staffs to handle the educational task single-handedly. At a minimum, allocate physician/faculty effort to help students process the experience, to provide students a conceptual framework, to examine, the physician's role, and to explore dynamics of working with an inter-disciplinary team.

- Provide support for alcohol treatment staff in their educational role. Help them develop their own styles, and try not to function according the their stereotypes of a professor. On the other hand, students mayweed some help in learning to learn from non-M.D.s, and the burden for conceptualizing may inevitably be upon the students.

- In most areas in clinical education, there is a tradition of setting physician trainees to work immediately, to learn "on-the-job." They may flounder initially, but usually do well enough based on technical knowledge and ferocious reading, combined with reasonable caution and generic professional behavior. Alcohol treatment provides enough conceptual surprises for the uninitiated, that this is rarely an efficient strategy. Students (or other trainees) should usually be allowed an initial period of immersion in, and observation of, a treatment program without clinical demands being placed on them. Having had time to make conceptual adjustments before being overwhelmed by the need to *do* something, they can then be put to work more fruitfully.

Jean Kinney, MSW
John Severinghaus, MD

May 1981