'The Teachable Moment' – opportunistic intervention for alcohol misuse.

EDITOR - Getz et al are right to say it is good medical practice to support health-promoting activities [(1)]. One example quoted is the 'teachable moment' for alcohol misuse. This uses the presenting complaint, e.g. fall, collapse, head injury, assault, accident, for the Accident and Emergency Department (A&E) as the 'learning opportunity' [(2)]. Thereby the patient may start to develop insight into the consequences of their drinking behaviour. Brief intervention (BI) is reported to be effective in the Emergency Room (ER) following injury, especially when carried out by Alcohol Health Workers secondary to initial detection from the medical or nurse practitioner dealing with the patient's presenting complaint [(3)].

Although the consequences of alcohol misuse are explained to the patient, to encourage the take up of the offered appointment with the AHW [(4)], the actual BI is not carried out in the initial consultation. Therefore this is not an additional role for the practitioner - that will create extra work and therefore possible stress – be it the General Practitioner or the A&E practitioner (nurse or doctor). Rather it is stress relieving to refer the patient on for BI – which is time consuming and requires special skills – in anticipation that the likelihood of reattendance and thereby further work is lessened.

We question whether the above has been taken into account by Beich et al [(5)], who do not specify 1.) If screening was selective for presenting conditions known to be associated with alcohol misuse (e.g. indigestion or lack of sleep) and 2.) If the BI - secondary to initial positive screening - was carried out by AHWs.

Screening needs to have a logical link to the patient's reason for initial consultation[(1)] if it is to be a true 'teachable moment'; it also then ethically correct, perhaps medico-legally correct as well!

Many 'Teachable moments' for underlying alcohol misuse are available in hospital, e.g. A&E, Facio-maxillary clinics, fracture clinics, Sexually Transmitted Disease clinics, to name but a few, as well as in General Practice. However these must not place additional workload on the practitioner, thereby risking clinical inertia. Rather extra resources are needed to fund AHWs, not only to provide expert BI, but also to provide training, encouragement and feedback for the referring doctors and nurses.

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1 Getz L, Sigurdsson JA, Hetlevik I. Is opportunistic disease prevention in the consultation ethically justifiable? *BMJ* 2003;327:498-500. (30th August.)
2 Huntley JS, Blain C, Hood S, Touquet R. Improving detection of alcohol misuse in patients presenting to an accident and emergency department. *EMJ* 2001;18:99-104.
3 Longabaugh R, Woolard RF, Niremberg TD, Minugh AP, Becker B Clifford PP et al. Evaluating the effects of a brief intervention for injured drinkers in the emergency department. *Journal of studies on alcohol* 2001;62:806-816.
4 Patton R, Crawford MJ, Touquet R. Impact of health consequences feedback on patients acceptance of advice about alcohol consumption. *EMJ* 2003:20:451-452.
5 Beich A, Thorsen T, Rollnick S. Screening in brief intervention trials targeting excessive drinkers in general practice: systematic review and meta-analysis. *BMJ* 2003;327:536-540. (6th September)

380 words excluding authors and references.