Attempts to spell out the nature of the relationship between alcohol consumption, alcoholism and disease have formed a well-established and lively debate. However, as Edwards¹ points out, ‘much of the necessary evidence on which to make a decision as to whether alcoholism is a disease is not yet available, and when all the relevant information on the causes of abnormal drinking has been gathered in, the decision as to alcoholism being a disease will still rest very much on the definition of “alcoholism” on the one hand and of “disease” on the other’. 

Consequences of Accepting a Wide-Ranging Disease Concept of Alcoholism

The statement ‘alcoholism is a disease’ is now so widely heard in scientific and lay circles that one can hardly safely begin any undertaking in reference to alcoholism without first repeating it.² 

If an increasing number of people are coming to accept as axiomatic that ‘alcoholism is a disease’ and are also defining as alcoholism ‘any use of alcoholic beverage that causes any damage to the individual or to society’ then certain things are consequent. These consequences, which have clear implications for those whose concern is with prevention, education and treatment, or with

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the provision of medical and social services associated with alcohol-related problems, are briefly discussed below. To an extent these consequences stem from the acceptance of any disease concept of alcoholism but clearly become more problematic and assume greater significance as a more wide-ranging disease conception is accepted.

**Consequence 1**

A person may define himself as an alcoholic, and thus his condition and behaviour as a medical matter, when the medical profession does not define the situation in that way, and vice versa. Whether the self-defined alcoholic’s definition of himself is accepted as appropriate by the medical profession as a whole, or by the particular member of the profession to whom the matter is presented, will depend upon how inclusive their disease conception of alcoholism is and whether they operate with similar criteria of what counts as alcoholism. If members of the medical profession operate with a restricted definition of alcoholism and a stereotype of the alcoholic as a ‘down and out’, recognisable by appearance, manners or loss of social position, then this has clear consequences for diagnosis and for their willingness to treat as legitimate the self-defined alcoholic’s presented complaint. Blane, Overton and Chafetz\(^3\) have demonstrated that alcoholics not conforming to the popular Skid Row stereotype are missed diagnostically, while Pattison\(^4\) reports that many doctors will not define as an alcoholic a person who is working and retaining his social and economic standards.

However, even if the medical profession’s definition is less inclusive than that of a presenting ‘alcoholic’, certain processes are likely to operate *in effect* to widen the disease conception in any particular case. These processes are inevitable, given the medical profession’s ethics, the fact that doctors are human beings and thus have a commitment and a general readiness to conceive of any presented complaint as an illness to be treated or at least as an appeal for help to them as doctors to be dealt with in some way. A member of the medical profession may thus be drawn as a medical expert into an area which he may feel ‘in his bones’ does not come within his competence to be expert about. However, the process does not stop here, for any intervention, however reluctant, will tend to reinforce