Guest editorial

Alfred Uhl, Julian Strizek, Blaine Stothard, Axel Klein and Aysel Sultan

Alfred Uhl is based at the Austrian Public Health Institute, Vienna, Austria and Sigmund Freud Private University, Vienna, Austria. Julian Strizek is based at Austrian Public Health Institute, Vienna, Austria. Blaine Stothard is an Independent Consultant at London, UK. Axel Klein is based at Global Drug Observatory, Swansea University, Swansea, UK. Aysel Sultan is based at Frankfurt University of Applied Sciences, Frankfurt am Main, Germany.

Alcohol has been consumed over thousands of years. More than any other psychoactive substance around the globe, alcohol is appreciated in many cultures as an essential element of culinary, cultural, religious and social life and associated with pleasure and well-being. At the same time, it has become increasingly obvious that excessive alcohol use commonly causes serious problems for drinkers, for their environment and for the whole society. Alcohol is hardly regulated in some cultures, strictly prohibited in others, and there are various approaches between these two extremes. The fact that alcohol is at the same time valued as a "source of enjoyment and pleasure" and condemned as an "addictive poison" makes regulating alcohol ambivalent and complex. Sigmund Freud (1905) described this ambivalence by describing alcohol in a single sentence as "valuable commodity" and "poison." He wrote "A change in mood is the most precious thing that alcohol achieves for mankind, and on that account this poison is not equally indispensable for everyone."

In some epochs and regions, the controversy between people demonizing alcohol and people trivializing alcohol was very strong. At the beginning of the 20th century, some Western countries enacted full-fledged alcohol prohibition, whereas others did not regulate alcohol-related matters at all. The degree of polarization in Western industrial countries regarding alcohol has significantly decreased since then. Nowadays, hardly anybody demands full-fledged alcohol prohibition and hardly anybody questions that a certain degree of control of use of alcohol is important, such as prohibiting intoxicated persons from driving or preventing the sale of alcohol to children or ensuring consumer protection to prevent highly toxic ingredients.

Alcohol is no longer considered to be an important medicine by physicians and researchers, even though popular lay medicine still promotes alcoholic beverages against certain acute diseases, such as the beginning of a flu-like infection to alleviate symptoms, and against ailments, such as a bloated feeling after having had a big meal. The idea that the US American physicians were entitled to prescribe whiskey for medical reasons to be sold and drunk in pharmacies during the alcohol prohibition in the 1920s and 1930s sounds rather strange to most observers nowadays. There is good empirical evidence that moderate alcohol consumption is associated with a higher life expectancy and undoubtedly alcohol use is associated with well-being and pleasure. On the other side, hardly anybody denies that alcohol intoxication is a serious risk when driving vehicles or operating dangerous machines and that excessive alcohol use reduces life expectancy and undeniably causes many physical, psychological and social problems.

However, although divergent opinions on alcohol have gradually converged, the average attitude concerning alcohol still varies considerably among different geographical regions. In the Protestant North of Europe and in parts of the English-speaking world, explosive drinking patterns prevail, and an alcohol-critical attitude dominates official public discourses. The adherents of this alcohol-critical position do not argue for full-fledged alcohol prohibition but define alcohol generally as a problematic commodity and support massive restrictions on alcohol consumption. On the other hand, the Catholic-influenced regions of Europe are characterized by socially integrated alcohol consumption patterns and traditionally stand for a more lenient alcohol-tolerant attitude. In these regions, moderate alcohol consumption is

associated with enjoyment and well-being, and only intoxication and excessive alcohol consumption are perceived as relevant social and health problem.

The credo of the alcohol-critical attitude is “Less is better,” taken from a book on the Paris WHO Conference on Health, Society and Alcohol (Anderson, 1996). The credo of the alcohol-tolerant position is “Drink responsibly!,” a slogan used by alcohol producers and to be found on a website of the US “Center for Disease Control” (CDC, 2019). Both slogans are interpreted as provocation by proponents of the other position. Supporters of an alcohol-critical position perceive the slogan “drink responsibly” as an unacceptable invitation addressed to abstainers to drink alcohol, which undermines their intention to give a negative spin to any alcohol consumption. Supporters of the alcohol-tolerant position perceive the slogan “Less is better!” as unjustified criticism of moderate and socially integrated alcohol consumption.

Proponents of the alcohol-critical attitude support restrictive approaches to protecting the population’s health, an approach commonly referred to as “public health approach” (Karlsson *et al.*, 2020). The more lenient approach to reach a healthy lifestyle supports health behavior but at the same time allows individuals to decide what to do by themselves in line with the “Health Promotion Approach” defined by the Ottawa Charter (WHO, 1986a). The authors of the Ottawa Charter (WHO, 1986b) explicitly refuse paternalistic ideas and state:

> There is a possibility with health promotion that health will be viewed as the ultimate goal incorporating all life. This ideology sometimes called healthism, could lead to others prescribing what individuals should do for themselves and how they should behave, which is contrary to the principles of health promotion.

For a long time, different perspectives in alcohol-critical and alcohol-tolerant regions did not induce any restrictions for those deciding national alcohol policies. Every country enacted its own policies without having to take other countries’ positions into account. This situation changed fundamentally when European integration resulted in abolished customs borders and free movement of EU-citizens as a fundamental principle of the European Union. Without tight border controls, high prices are much easier to circumvent – legally or illegally – by purchasing alcohol in neighboring low-price countries. If citizens start to appreciate more liberal attitudes toward alcohol in other countries, they are less willing to accept severe restrictions and high prices in their own countries. With less power to regulate on a national level and increasing regulations on the European level, a realistic way to preserve a restrictive traditional alcohol policy is to convince other European countries of a restrictive alcohol policy on the European level. Since the alcohol-critical countries were dedicated to keeping their traditional alcohol policies, they started intensive lobbying – or more neutrally expressed “advocacy” – on the European level to convince lenient countries to reconsider their approach. Traditionally, alcohol-critical countries invested much money into epidemiological alcohol research, whereas alcohol-tolerant countries had not done so. Robin Room(1990, p. 90) described alcohol research as the “residual legatee of a formerly strong temperance movement.” Where the temperance movement was strong much research to back up the movement was funded. This imbalance is reflected in the scientific arena, with many renowned researchers with an alcohol-critical background and comparatively few from alcohol-tolerant regions. In a commonly used narrative, restrictive alcohol control strategies are presented as “evidence-based policies” supporting public health interests against the financial interests of the alcohol industry. This narrative was developed over many decades via several publications (Bruun, 1975; Edwards *et al.*, 1994; Babor *et al.*, 2003, 2010; Anderson and Baumberg, 2006) by alcohol-critical authors, many of them serving in WHO expert committees and consequently promoted by WHO. Because of this support, the publications reached enormous impact within the public health sector and alcohol research. In a text released by WHO and the World Economic Forum (Bloom *et al.*, 2011), the key recommendations of these publications were combined to the catchword “three best buys.” These recommendations are:

1. higher taxes on alcohol;
2. severe restrictions on the number of locations selling alcohol and on their opening hours; and
3. a strict ban on alcohol advertising. The explicit claim is that these – and only these – measures are both effective and cheap at the same time.

In line with the Austrian philosopher Liessmann(2009), the persuasiveness of this narrative can be explained with the mechanism of "performative self-immunization of terms." "Performative self-immunization" works by formulating propositions containing words that to observers irresistibly suggest something positive that they actually do not indicate. Liessmann claims that it is risky for critics to argue against certain terms – in this case "evidence-based," "health interests" and "opposition to positions that advance the financial interests of the alcohol industry" – as turning against these terms systematically undermines the reputation of those who criticize.

The term "evidence-based alcohol policy" in this context is problematic for two reasons. First, "evidence" suggests a high degree of validity although the available evidence can be more or less conclusive. Most evidence used to support a restrictive alcohol policy approach is not experimental but of an observational nature. Interpreting observational data requires more or less arbitrary assumptions and commonly leaves much room for alternative conclusions. To implicitly present tentative conclusions as facts is undoubtedly useful from an advocacy perspective, but inadequate from a scientific perspective. Second, the term "evidence-based alcohol policy" suggests that what should be done can be derived from what there is – a fundamental misconception that Moore(1960) labeled "the naturalistic fallacy." There is no doubt that factual arguments relevant for political decisions should be correct, but what should be done is highly grounded in value judgments, which depend on prevailing worldviews of decision-makers – an aspect systematically camouflaged by this terminology (Uhl, 2007). The inherent value decisions are hardly ever simple, as political decisions in a modern democratic society need to be proportionate. Proportionality means that all factual and value judgments for and against a certain strategy must be systematically weighed against each other (Uhl, 2020).

Framing alcohol policy as a dichotomous conflict between the "health interests" of a chronically underfunded public health sector and the "financial interests of a powerful alcohol industry" is misleading as well for several reasons:

- This dichotomy camouflages that alcohol policy involves more than just two groups of stakeholders. An important group to consider is consumers of alcohol, with a majority of them drinking moderately in order to enhance well-being and pleasure.
- Second, subjective interests are only linked to the alcohol industry, ignoring that employees of the public health sector and in alcohol research have vested interests as well. All employees in all sectors are motivated not to jeopardize their own professional situation. Of course, interests of economic stakeholders follow different rules than interests of scientific stakeholders; however, it is advisable to consider the motivation of all involved parties when judging their conclusions. To assume that only one side has vested interests and to intuitively side with the financially less potent side is utterly naïve.
- The third important argument in this context is that any piece of scientific conclusion should be solely judged by its scientific merit.

Rothman(1993) rigorously rejected any manipulative and unsound rhetorical strategy to undermine the reputation of a person or institution who supports a certain proposition without considering the validity of the arguments (*argumentum ad hominem*). He labeled the fact that

the work of certain groups is automatically rejected and not published because of presuming a conflict of interest, which has been described as "New McCarthyism in Science."

Mainstream alcohol epidemiological research is presently dominated by researchers supporting a restrictive alcohol policy approach and advocating this position. An advocacy perspective induces an inherent conflict with central basic research principles though. The inherent role of advocates is to selectively look for arguments supporting specific positions and aiming at plausibility, whereas the task of researchers is to consistently and critically scrutinize all positions – including their own. In line with Popper's (1935) concept of critical rationalism, the aim of science is to develop as many different hypotheses and theories as possible and to question them systematically until the most likely options on empirical and rational grounds remain – that way gradually approaching truth. Popper in this context wrote: "He who does not expose his thoughts to refutation does not take part in the game of science." Researchers should not hide ambiguities and uncertainties. They should discuss them openly to continuously move closer toward a correct and logically consistent picture of reality (Ball *et al.*, 2019).

To avoid creating a one-sided image: There are several renowned and widely accepted researchers taking critical positions on mainstream alcohol policy, such as Mäkelä(2012) fundamentally criticizing the popular "cost of alcohol" study approach, Poikolainen(2016) criticizing the weakness of strict alcohol control policies, and many more. However, the impact of these critical contributions on the mainstream alcohol policy discourse is limited. This issue of "Drugs and Alcohol Today" presents some ideas and perspectives underrepresented in the current alcohol policy discourse as a contribution to a more diverse and balanced alcohol policy discourse.

References

Anderson, P. (Ed.) (1996), *Alcohol - Less is Better*, European Series, No. 70, WHO Regional Publications, Copenhagen.

Anderson, P. and Baumberg, B. (2006), *Alcohol in Europe: A Public Health Perspective*, Institute of Alcohol Studies, London.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Gruenewald, P., Hill, L., Holder, H., Homel, R., Österberg, E., Rehm, J., Room, R. and Rossow, I. (2003), *Alcohol: No Ordinary Commodity - Research and Public Policy*, Oxford University Press, New York, NY.

Babor, T., Caetano, R., Casswell, S., Edwards, G., Giesbrecht, N., Graham, K., Grube, J., Hill, L., Holder, H., Homel, R., Livingston, M., Österberg, E., Rehm, J., Room, R. and Rossow, I. (2010), *Alcohol: No Ordinary Commodity Research and Public Policy Second Edition*, Oxford University Press, New York, NY.

Ball, D., Humpherson, E., Johnson, B., McDowell, M., Ng, R., Radaelli, C., Renn, O., Seedhouse, D., Spiegelhalter, D., Uhl, A. and Watt, J. (2019), "Improving society's management of risks – a statement of principles", *Collaboration to Explore New Avenues to Improve Public Understanding and Management of Risk (CAPUR)*, Atomium-EISMD, Brussels.

Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R.E., Room, R., Schmidt, W., Skog, O.J., Sulkunen, P. and Österberg, E. (1975), "Alcohol control policies in public health perspectives", *Finish Foundation for Alcohol Studies*, Vol. 25.

Bruun, K., Edwards, G., Lumio, M., Mäkelä, K., Pan, L., Popham, R.E., Room, R., Schmidt, W., Skog, O.J., Sulkunen, P. and Österberg, E. (1975), "Alcohol control policies in public health perspectives", *Finish Foundation for Alcohol Studies*, Vol. 25, Helsinki.

CDC (2019), "Centers for disease control and prevention – dietary guidelines for alcohol", available at: www.cdc.gov/alcohol/fact-sheets/moderate-drinking.htm (accessed 16 May 2020).

Edwards, G., Anderson, P., Babor, T.F., Casswell, S., Ferrence, R., Giesbrecht, N., Godfrey, C., Holder, D.H., Lemmens, P., Mäkelä, K., Midanik, L.T., Norström, T., Österberg, E., Romelsjö, A., Room, R., Simpura, J. and Skog, O.J. (1994), *Alcohol Policy and the Public Good*, Oxford University Press, Oxford.

Freud, S. (1905), "Jokes and their relation to the unconscious", Free eBook from www.SigmundFreud.net, available at: www.sigmundfreud.net/jokes-and-their-relation-to-the-unconscious.pdf (accessed 24 July 2020).

Karlsson, T., Mäkeläa, P., Tigerstedt, Ch. and Keskimäki, I. (2020), “The road to the alcohol act 2018 in Finland: a conflict between public health objectives and neoliberal goals”, *Health Policy*, Vol. 124 No. 1, pp. 1-6.

Liessmann, K. (2009), Theorie der Unbildung – Die Irrtümer der Wissensgesellschaft (2. Auflage).

Mäkelä, K. (2012), “Cost-of-alcohol studies as a research programme”, *Nordic Studies on Alcohol and Drugs*, Vol. 29 No. 4, pp. 321-343.

Moore, G.E. (1960), *Principa Ethica*, University Press, Cambridge, Original: First Edition (1903).

Poikolainen, K. (2016), “The weakness of stern alcohol control policies”, *Alcohol and Alcoholism*, Vol. 51 No. 1, pp. 93-97.

Popper, K.R. (1935), *The Logic of Scientific Discovery*, Vol. 2005, Taylor and Francis e-Library, London.

Room, R. (1990), “Recent research on the effects of alcohol policy changes”, *The Journal of Primary Prevention*, Vol. 11 No. 1, pp. 83-94.

Rothman, K.J. (1993), “Conflict of interest”, *Jama: The Journal of the American Medical Association*, Vol. 269 No. 21, pp. 2782-2784.

Uhl, A. (2007), “How to camouflage ethical questions in addiction research”, in Fountain, J. and Korf, D.J. (Eds), *Drugs in Society European Perspectives*, Radcliffe, Oxford, pp. 116-130.

Uhl, A. (2020), “Framing substance use problems - influence on key concepts, methods of research and policy orientation”, in MacGregor, S. and Thom, B. (Eds), *Risk and Substance Use Framing Dangerous People and Dangerous Places*, 1st ed., Routledge, London, pp. 222-236.

WHO (1986a), *Ottawa Charter*, World Health Organisation, Geneva.

WHO (1986b), “Health promotion: a discussion document on the concepts and principles”, *Health Promotion*, Vol. 1, pp. 73-76.

Further reading

Courtwright, D.T. (2001), *Forces of Habit*, Harvard University Press, Cambridge.

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