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Cheryl L. Krasnick

"Because there is pain":
Alcoholism, temperance and the Victorian physician

The effects of beverage alcohol and its use in therapeutics were matters of continuing debate for the medical profession in Victorian Canada. Practitioners, many of whom perceived alcoholism as a disease, were instrumental in the early organization of the temperance movement. However, as the temperance movement gained momentum, the medical profession was unable to appropriate alcohol abuse as a medical concern, as it had drug addiction. At the same time, threats to its professional autonomy, differing class and ethnic loyalties, and disagreement over the vogue of alcohol therapy, divided the profession and publicly illuminated inconsistencies in its position. The profession consequently failed to gain public support for the exclusive medical management of alcoholism.

This paper will examine the early brief alliance and subsequent lengthy conflict between the medical profession and the temperance movement. Through examination of medical journals, government testimony and institutional reports, the divisions within the profession over the use of alcohol in therapeutics and over the consequences of legislated prohibition for the profession will be discussed. Finally, it will be demonstrated that the profession's conception of alcoholism as a medical concern, attended by research on the causes, classification and treatment of alcoholism, did not find widespread public acceptance, due largely to the doubt it cast upon the effectiveness of prohibition in ameliorating social ills.

Liquor was an essential household item for much of the nineteenth century. As a beverage, it was considered safer than milk or water, and until the 1830-40s, cheaper than tea or coffee. As a "social lubricant", it facilitated relations between friends, tradesmen and travellers, and functioned as a commodity of exchange for pioneer areas short of specie. In Upper Canada in the 1830s, taverns were used as meeting-halls, polling-stations and churches and otherwise served as community centres.¹

Alcohol was popularly believed to have medicinal qualities. It stimulated and supported the system, prevented fevers and infectious diseases, and provided the stamina necessary for hard physical labour. As a tonic, tincture or beverage, alcohol was employed by medical practitioners, lay healers and in ordinary households to heal wounds, counteract debilitating conditions, help digestion and even induce the flow of milk following childbirth.²

Given the widespread use of alcohol in health, disease and diet, it is not difficult to predict increasing incidence of alcohol abuse. The wide availability of distilled spirits in North America, coupled with greater mobility and attendant decline of cultural controls on use, led to a rise in alcohol consumption which peaked in the 1830s.³

In response, the Canadian temperance movement was organized on two fronts. In English Canada, spearheaded by the Presbyterian Montreal Temperance Society and its organ The Canada Temperance Advocate, the anti-liquor crusade of the 1830s and 1840s found its greatest support in rural areas, small towns and among the elite of the working class. In French Canada, temperance took the form of a mass movement, led by charismatic figures such as Monseigneur Forbin-Janson and Father Charles Chiniquy. In both French and English Canada, temperance during the 1840s was a popular movement; it was estimated that one-third of the total population of Canada East and Canada West had pledged to abstain from alcohol.⁴

As the movement grew, the expectations of its followers rose accordingly. On an individual level, temperance reformers believed it possible to "reverse one's life situation" by practicing sobriety. On a social level, prohibition was touted as the panacea for society's ills. The goals of the movement therefore were broadened to include more than a decrease in alcohol consumption, but the eradication of all "poverty, crime and degeneracy".⁵

By mid-century, the early temperance fervour had cooled and pledges were quietly broken. The core of the movement, predominantly Protestant and middle class, remained convinced that prohibition could eliminate indigency and disease, and also increase worker efficiency and reliability. Dissatisfied with the lack of results produced by the religious and popular campaigns, temperance supporters lobbied government for legislated prohibition. The movement scored its first legislative victory in 1855 with the enactment of a prohibition law in New Brunswick, following a wave of enthusiasm engendered by Neal Dow, the temperance crusader of the neighbouring state of Maine. The New Brunswick experiment, however, was repealed within a year by an unsympathetic Lieutenant-Governor. In 1875, sufficient temperance pressure had been placed upon the Dominion government to warrant the creation of a Royal Commission to investigate temperance legislation. In 1876 The Crook's Act, a licensing law, was passed in Ontario. In 1878 The Canada Temperance Act or Scott Act was proclaimed which allowed for local option; by referendum, cities and counties could prohibit liquor sales within their own districts. Despite the gaping loopholes intrinsic in such legislation, the move was extremely controversial, and the Scott Act had been rejected by the voters in every Canadian district by 1889. In 1892 a Royal Commission on the liquor traffic was again established; its report was the framework upon which national prohibition, established in Canada in 1918 would be based. The Commission's major recommendations included a stricter licensing policy, inspection for adulteration, separate

sales of groceries and liquor, and a new referendum on the Scott Act. The Commission also suggested that alcoholics be removed from common jails and placed in "proper places where they can be restrained indeterminately".⁶

This last point was a small victory for inebriate experts in the medical profession who had agitated for special asylums for a half-century. The principles they developed included a preference for true temperance, not prohibition, achieved through education rather than legislation; the establishment of public inebriate asylums for all sufferers, not just convicted offenders or those able to afford private retreats; and most importantly, the acceptance of alcoholism as a hereditary neurotic disorder for which alcohol abuse was only a catalyst. These principles were virtually absent from the final recommendations of the Commission. They were however remarkably consistent with the conclusions reached by Benjamin Rush, the noted American physician and "patron saint" of the temperance movement.

Pre-Enlightenment thought held that alcohol abuse was an act of free will characterized by an excessive love of liquor. That alcohol abuse might also involve an involuntary element and might be, in some cases, classified as a disease, was first advanced by Rush in 1784. In An Inquiry into the Effects of Ardent Spirits, he described the gradual and degenerative nature of alcoholism. Rush recognized the "craving" for alcohol or addiction process to be irresistible once fixed. He advocated "personal abstinence from hard liquor" (not tee-totalism), "strict sanctions" against drunkards, and the removal of the alcoholic from the community until sober. The first statements of alcoholism therefore contained the first mention of the inebriate asylum.⁷

The early temperance movement had the effect of inducing physicians to prescribe substitutes for alcohol, which at first presented few

difficulties as other remedies such as calomel, opium, Peruvian Bark and antimony played far more important roles. However popular rebellion against such "heroic" therapeutics and the threat of competition from homeopaths and other irregulars sent physicians searching for new medicines — and developing a renewed appreciation for the mild and palatable effects of alcohol. Thanks to the agitation of the temperance movement, liquor was becoming less of a household item, and more an appropriate candidate for the physician's pharmacopeia.⁸

The role of the medical profession in the temperance movement declined with the rapid growth of the American and Canadian temperance societies by the 1840s. When leaders called for total abstinence, physicians increasingly were alienated, especially when irregulars appeared in the ranks of temperance advocates. The temperance movement in turn was dealt a heavy blow in the 1850s when medical studies from Europe disclosed that alcohol in moderation was not detrimental to health as temperance advocates had claimed. The growing schism between the two groups was apparent in the words of J. S. Beck, an American physician, who stated in 1856, "I am as much in favour of temperance as any one, and I look upon the temperance reform as one of the great moral triumphs of the age. But so good a cause does not require to be supported by a violation of truth: the unchastened zeal of many so-called temperance men has already done much mischief, and I fear will do much more".⁹

The final break occurred in the 1860s with the development of a system of therapeutics based upon the stimulating properties of alcohol. The conceptual framework in which alcohol therapy operated drew on a tradition in medical understanding which dated to the excitability theory developed by William Cullen and John Brown of Edinburgh. The Edinburgh school postulated that illness was caused by an imbalance of nervous system activity, over-activity producing a sthenic state, and underactivity resulting in asthenic conditions. In most cases,

disease produced debility or depletion of energy, a condition which required stimulation.¹⁰ It was within this general medical context that Robert Bentley Todd of London, England declared alcohol to be the most effective stimulant. He characterized disease as the "depression of vital power" which necessitated the "stimulating and strengthening" powers of alcohol to support the natural healing process. Alcohol rapidly became an indispensable part of the physician's pharmacopeia, and almost as rapidly, a controversial item.¹¹

Todd's basic premise was that alcohol was nourishment "broken down in the body by oxidation". Following his death in 1860, this premise was disputed by Ludgar Lallemand and Edward Smith, (French and English researchers respectively) who found that alcohol was eliminated unchanged from the body. Within a year, the "Lallemand-Smith total elimination theory" was "for the most part" accepted by the British medical profession. Few physicians however took the next logical step of banishing alcohol from their practices, preferring to follow their own clinical experience until a more effective and benign therapeutic tool presented itself.¹²

The British debate over alcohol's chemical properties and therapeutic uses spilled over into the colonies. In 1877-8, when the "use of spirits" in the medical treatment of the insane became an issue in the Ontario legislature, asylum superintendents were forced to face the question and voice their opinions. John Dickson, superintendent of the Rockwood Asylum at Kingston, was an early opponent of alcohol therapy. In 1878 he wrote, "I am well aware that some physicians claim a power for alcohol it does not possess. They prescribe it as a restorative, and assert that in wasting diseases it is useful in...preventing waste of tissue, neither of which effects I am quite positive it possesses... It is a most destructive agent to every organ or tissue of the body either in a state of health or disease."¹³

At this time, Dickson was in the minority. Joseph Workman, superintendent of the Provincial Asylum at Toronto, stated bluntly that "total abstainers should leave the domain of medicine". Henry Landor of the London Asylum believed that alcohol tended to "restore the vital powers". When he briefly bowed to the opinion of "a large class of the people" and cut off stimulants from feeble patients, he blamed this action for the rise in the asylum death rate.¹⁴

The staunchest defender of stimulant therapy was Daniel Clark, Workman's successor at the Toronto Asylum. In his lengthy reports, Clark was at his most eloquent on the question of alcohol. "If...the use of alcohol as a medicine is so destructive, pernicious and injurious to patients," he stated, "the results flowing from the...treatment would be so marked that [their] presentation...would be an end to all controversy." "It cannot be denied", he added, "that alcohol as a beverage has done incalculable injury to society...In health no one needs it, and in disease it has to be given with discretion and judgement." Like Landor, Clark considered the abuse of narcotics to be "more pernicious than alcoholism". His strongest argument against the prohibitionists was a table comparing the use of chloral hydrate and opium at the Toronto, London and Kingston Asylums for the years 1876 to 1878. At the Toronto Asylum, where both narcotics and alcohol therapy were prescribed, 3500 patients were prescribed 25 ounces of chloral hydrate and six ounces of opium. The Kingston Asylum under Dickson, with one-half as many patients as Toronto, used ten times as much chloral hydrate and nearly four times as much opium (see Table One).¹⁵

By the late 1880s and the 1890s, as prohibitionist sentiment heightened, Dickson was replaced as temperance advocate by the formidable Richard Maurice Bucke. Bucke earlier had outlined his views in Alcohol in Health and Disease, in which he stated that alcohol was dangerous in either state. Accordingly in 1879 he virtually ceased using alcoholic stimulants at the London Asylum. By 1885, to his chagrin, changes

TABLE 1

CHLORAL HYDRATE AND OPIUM USED IN TORONTO, LONDON
AND KINGSTON ASYLUMS, 1875-1878

	<u>Drugs</u>	<u>Quantity Used</u>	<u>Total Patients</u>	<u>Total Used Per Head</u>
TORONTO	Chloral Hydrate	25-1/2 oz.	3,469	3.21 grs.
	Opium	6-1/2 oz.	3,469	.90
	Morphia	2 drs.	3,469	.03
LONDON	Chloral Hydrate	62 oz.	2,975	10 grs.
	Opium	28-2/3 oz.	2,975	4.62
	Morphia	1 oz. 1 dr.	2,975	.11
KINGSTON	Chloral Hydrate	258-2/3 oz.	1,720	72.12 grs.
	Opium	22-1/3 oz.	1,720	6.23
	Morphia	2-1/2 oz.	1,720	.69

NOTE: In the above table the following preparations of opium have been excluded from the quantities used by the different asylums, viz: Tinc. Camph. Co., and Pulv. Co. as these drugs are not used to quiet patients.

Annual Report of the Inspector of Prisons and Asylums, "Report Toronto", 8, 1879

in the death and recovery rates were minimal; his experiment was inconclusive, and he was forced to backtrack. "I never supposed", he quibbled, "that three or four dollars worth per patient per annum...would...materially shorten life. I simply said that alcohol did no good..." By 1889, Bucke was able to report a drop in the asylum death rate from 5.5 to 4.5 percent, a figure which he described as "remarkable". Recovering his customary élan, Bucke concluded that alcohol "both as an article of diet and as a medicine was a failure".¹⁶

If medical attitudes were divided over the use of alcohol as a drug, they were no less so over the issue of legislated prohibition. Many physicians joined Francis Ogston, President of the Aberdeen (Scotland) Medical Society, in asking, "Is it undeniably certain that all crimes, vices [and] weakness [are] traceable to liquor?" Dr. Vesey Brown of London, Ontario, an opponent of prohibition, agreed that the Scott Act had taught restraint, but maintained that a prohibitory law would be "very tyrannical" by restricting "the liberty of those who [knew] how to use liquor". He believed that "in moderation, good beer or good whisky is not injurious, particularly for certain [rheumatic] constitutions". T. F. McMahon, a Toronto physician, believed it impossible to compound or dispense drugs without alcohol, as temperance physicians had suggested. "It is as absolutely necessary as any one drug...I believe the use of alcohol sometimes saves life."¹⁷

By 1894, however, the majority of Canadian physicians tended to favour prohibition. Edward Fisher of Toronto looked upon alcohol as "a cancer in the body politic...absolutely injurious in any quantity, just in proportion to the quantity taken". As for the therapeutic value of alcohol, Fisher considered it to be "the bane of the profession...I am satisfied that the earth covers a good many cases labelled pneumonia, typhoid fever, and so forth, that might be more truthfully labelled the result of alcohol". Henry Arnott of Loudon believed that "alcohol should be seen as a narcotic the same as any other narcotic" and made

inaccessible to the public.¹⁸

Such differences of opinion were not based solely upon therapeutic preferences or scientific allegiances. When a cursory survey is made of physicians from Quebec, Ontario and Nova Scotia interviewed during hearings of the Royal Commission on the Liquor Traffic in 1894, it is found that all those favouring prohibition were of British origin, while those opposed were either German, French-Canadian, or English Quebec residents.

German-Canadian physicians from the Berlin-Waterloo, Ontario area shared the view of their compatriots that alcohol, particularly beer, was a necessary and healthy staple of the diet and that temperance was an unwarranted intrusion on personal habits.

French-Canadian drinkers (and non-drinkers) felt the intrusion more keenly. Just as the Quebec temperance movement in the 1840s had taken on a nationalist and religious character, anti-temperance in the 1890s was based upon a distrust of any federal legislation aimed at curbing individual choice — particularly legislation initiated by English Protestant lobby groups. German, francophone and anglophone Quebec physicians were skeptical that legislation so unpopular in their own districts could be enforced.

The debate within the profession over alcohol did little to enhance the credibility of physicians in the eyes of the public. This had been evident in 1874, when a two-man Royal Commission was appointed by the federal government to enquire into the working of the prohibitory liquor laws in the United States. Commissioners F. Davis and Reverend J. W. Manning visited the New England and Midwestern States where prohibition legislation was in force. They obtained "extracts from public documents", visited the "lowest quarters of various cities" under the "protection of policemen" and went "where large crowds were likely to be gathered". The Commissioners also interviewed scores of individuals,

including governors, clergymen, army officers, jailors, editors and "employers of labour". Nowhere, however, was it mentioned that the Commissioners had questioned members of the medical profession. In 1874, at the height of the popularity of alcohol therapeutics, the aims of the medical profession were not perceived to coincide with those of prohibitionists.¹⁹

During the 1890s, moreover, the opinions of Canadian doctors do not seem to have been sought with any more enthusiasm, despite the tendency for physicians to approve of prohibition on an individual level. Far more comprehensive than the investigations of twenty years earlier, the 1894 Commission interviewed influential citizens across Canada. Five percent (14) of those interviewed in Ontario were physicians (see Table 2). As a group, physicians were represented in fewer numbers than businessmen, those involved in the liquor industry, and clergymen. Alcohol abuse was still not perceived to be a predominately medical question.

The issue of the use of alcoholic stimulants in medical practice was more than an internal wrangle over therapeutics. For physicians such as Daniel Clark and Joseph Workman, it was a question of professional autonomy — not "what shall we use" but "who shall decide". In the latter part of the nineteenth century, for the process of professionalization to be successful, every aspect of therapeutics had to be under the control of medical practitioners, and every lay or government move in the area of therapeutics to be considered threats to the profession. For physicians to have their choice of drugs determined by election campaigns, temperance rallies or church meetings was to make a mockery of attempts to consolidate an autonomous profession. As Clark stated with apparent bitterness after the 1877 debate in the Ontario legislature mentioned above, "It is a matter for congratulation to know that our Legislature [has] made the subject of the medical treatment of the insane a matter of intelligent study, and that each speaker could show ...grounds for his medical opinions on this difficult problem...I

TABLE 2

OCCUPATION OF WITNESSES TO THE 1894 HEARINGS
OF THE ROYAL COMMISSION ON THE LIQUOR TRAFFIC (ONTARIO)

<u>OCCUPATION</u>	<u>NO.</u>	<u>X</u>
Government	65	23
Judiciary/Law Enforcement	46	16.5
Business	38	13.5
Liquor Industry	20	7
Charities	16	5.5
Physicians	14	5
Religion	41	14.5
Other	42	15
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TOTAL	282	100
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feel bound to say this, on account of the many enquiries made by [American] superintendents of asylums...as to the reasons of this unique debate on the subject of medical treatment..."²⁰ The question was one of control, and whatever their personal beliefs on the advisability and benefits of alcohol use in therapeutics, many physicians considered anti-liquor legislation, whether laid down by community organization or by law, to threaten their professional independence.

Coincident with the rise of alcohol therapeutics and the controversy it created was the formulation of the disease concept of alcoholism. The attempted appropriation of "inebriety" by the medical profession was clearly stated in 1900 by William Westcott of Britain who wrote, "The relief of the sufferer from alcoholic excess is a purely medical question of medicinal treatment on ordinary therapeutic lines, and...the tendency to inebriety can only be overcome by a period of hygienic restraint in an institution regulated by law and managed by medical men who have had experience in the treatment of mental degeneracy and physical incapacity".²¹

The disease of inebriety, first defined by Rush, manifested itself in acute, periodic and chronic forms. Acute alcoholism, which entailed excessive alcohol use over a short period of time, was associated with stress or misuse of stimulants introduced in therapy, and was considered to have a high success rate of cure. Periodic insanity, or dipsomania, was of great interest to physicians as its sudden and mysterious onset and remission lent themselves to comparison with insanity. Chronic alcoholism or "habitual drunkenness" was manifested by tolerance, physiological changes over time, withdrawal cravings and loss of control. All of these features were restated in the 1940s by E. M. Jellinek in his landmark The Disease Concept of Alcoholism.²²

With respect to the causes of inebriety, there were many theories postulated. Benjamin Rush's early model presented alcohol as the sole causal agent. Other practitioners subsequently refined this theory.

In 1858, David Skae of Britain viewed alcoholism as a moral insanity characterized by loss of control, rather than just as an addiction to alcohol. According to Skae, the craving for alcohol was only one symptom of "moral perversion". Others included lying, licentiousness, mischief and theiving. Alcoholism therefore was only one of a series of antisocial traits both hereditary and acquired. Significantly, Skae placed little of the responsibility for "dipsomania" on alcohol itself, and he clearly believed that since alcoholism was the consequence of a moral failing, legislated prohibition would do little to reduce crime, disease and indigency, as temperance advocates had claimed.²³

Because the personality changes and behaviour patterns resulting from inebriety so resembled insanity, the experts, most of whom had had experience practicing in asylums, described it in the same terms as insanity, and eventually concluded that alcoholism was in fact a manifestation of a previous mental imbalance. Causes of inebriety included shock, bereavement, family or business troubles, head injuries and illness, all of which were also cited as "exciting" causes for insanity. T. D. Crothers, the premier American authority, stated that "the use of spirits was not always the cause of inebriety" — a predisposition must exist. He observed that cases of periodical inebriety in remission often were wrongly attributed by the public to temperance pledges, drugs or fad cures. Unlike Skae, who believed it unnecessary and harsh to institutionalize periodic drinkers, Crothers argued that "only hospital treatment over long periods" would cure the disease. "Inebriety", he stated, "is insanity, obscure and masked, starting from the same range of physical causes, following the same lines of progress, and curable in substantially the same way."²⁴

The predisposing cause most commonly associated with insanity in the nineteenth century, and whose application to alcoholism proved the most controversial in the view of adherents to the temperance movement, was heredity. Crothers estimated that two-thirds of all cases of

inebriety were inherited — citing inebriates, the insane, epileptics or "neurotics" among the ancestors of alcoholics. He considered the "morbid impulse" for alcohol or other drugs to result from an inherited "mental instability and feebleness".²⁵

In 1897, Stephen Lett, one of Canada's leading addiction authorities, shared Crother's view of alcoholism as originating from an inherited weakness. "Men drink", he stated, "because there is pain" — a "feeling of disturbance" caused by an hereditary taint, or by the closely allied practice of "feeding children nourishment surcharged with alcohol".²⁶

The role given heredity as a predisposing cause of inebriety offered a fatalistic prognosis for the eradication of alcoholism and minimized both the part liquor played and the benefits of temperance. Temperance advocates objected to these premises. John Ordronaux, for example, who was an American welfare administrator, deplored the evolution of a system of law and values which negated individual responsibility for sin by putting "the blame on the Creator". "Every vice and crime", he wrote, "is now called a disease". He admitted that children of drunkards may inherit a tendency towards drink, but this did not prove "a moral or physical obligation to drink". "No man", he added, "ever became a drunkard by spontaneous evolution". Ordronaux, who was not a physician, also pointed out the weaknesses of the disease model of alcoholism. If it were a disease, "why can't it be cured? What kind of disease existed where symptoms can be produced or dismissed at the will of victims?" "Inebriety," he concluded, "is not a disease but a self-provoked temporary perversion of our natural functions, induced for purposes of sinful gratification."²⁷ For this reason, Ordronaux regarded the establishment of hospitals for inebriates as encouragement and sanction for vicious conduct.

Ordronaux was correct in concluding that the cognitive aspect of alcoholism was often minimized by the inebriate experts. Clinical

work in private institutions had shown that alcoholic cases shared common characteristics with cases of mild depression, nervousness and other neuroses lumped under the diagnosis of "neurasthenia". Alcoholics also had histories of overwork, family troubles and "hereditary taint". Was alcoholism a cultural problem solved by abolition of liquor or a psychological disorder cured by institutional care? The inebriate experts attempted to reconcile clinical evidence with the views of temperance reformers — views which as members of the middle class they themselves shared, and which had far-reaching consequences for the future of social reforms based upon temperance.

George M. Beard, a foremost Victorian neurologist from the United States, revealed personal class prejudices by distinguishing the neurosis of "inebriety", prevalent among the upper and middle classes, from the vice of drunkenness, a predominantly lower class phenomenon. Inebriety, he explained, increased "with the increase of civilisation". The middle class man was both pampered and threatened by urban life and technological advancement. Excessive "brain work" and the struggle for success produced a constitution too delicate to handle excessive amounts of alcohol, and its use among the middle class was of necessity decreasing. Those who mistakenly believed alcohol to be fortification against a bustling world often fell victim to the disease of inebriety. The "lower classes", on the other hand, lived in a state of "semi-barbarism". They were superstitious, their mental disorders took the form of insanity rather than neuroses, and their constitutions were able to sustain higher doses of alcohol. Cases of alcohol abuse among the lower class, Beard concluded, resulted from vicious conduct — the vice of drunkenness.²⁸

As proof of his model of vice among the poor and disease among the rich, Beard offered the tautology that "professional and businessmen [are] the very class...that supplies the victims of our inebriate asylums" — which invariably charged hefty fees. By labelling alcohol abuse in a form palatable to the middle class patient, the physician had

simultaneously created a profitable practice for himself.²⁹

When the specialists turned from medical theory to professional action, the consequences of their ambiguous policies, publicly perceived to be anti-temperance, became apparent. As the experts attempted to organize themselves and agitate for the establishment of asylums in which to test their theories, they encountered disinterest and hostility.

In 1870, Drs. Joseph Parrish and Willard Parker founded The Association for the Study of Inebriety in the United States, and its membership soon included Canadian specialists. The aims of the organization included professional recognition, government construction of asylums, and the transfer of the inebriate from the prisons to the asylums for compulsory treatment.³⁰

According to its president, Theodore L. Mason, the founding of the organization was followed by an "unprecedented violent attack" from religious leaders. Inebriety as a disease was "represented as framing an apology for sin and crime". But, Mason added, "by stating [that] the sin of habitual drinking was the cause [and the disease the effect], we won over our opponents".³¹ Clearly the Association was not dogmatic about the scientific definition of the disease, overlooking the hereditarian premises they themselves had put forth. The Association's ambiguous principles reflected the ambivalence of the membership — as they shared with the temperance movement the perception of a "shiftless" drunken poor and the belief in the need to uphold middle class values. Yet the ambiguities were sufficient to ensure the exclusion of the medical profession from the forefront of the "liquor problem".

The movement for inebriate asylums faced intractable difficulties in Canada. An early victory was overturned in 1874 when the Hamilton Asylum, constructed for alcoholics, was converted into an insane asylum before completion. In explaining his decision, J. W. Langmuir, Ontario's Inspector for Prisons and Asylums, wrote "While I continue to hold

the opinion that an effort should be made to reclaim drunkards...the claim of [the insane] is far more pressing and urgent than that of men labouring under a diseased appetite for strong drink."³²

Although no action was taken to provide an inebriate asylum for the public, there was agitation for it. Dr. A. M. Rosebrugh, a Toronto physician, was a crusader for the establishment of public inebriate asylums in Canada. In 1890-91, he served on the Ontario Prison Reform Commission to determine the relationship between intemperance and crime and in 1895, sponsored by the Prisoners Aid Association of Canada, he interviewed a number of North American inebriate specialists, including Lett, Crothers and Mason.

The Prison Reform Commission recommended compulsory commitment of habitual drunkards to an industrial reformatory where the men would labour in farming, market gardening and "suitable industrial occupations". The government shelved the findings, judging the reformatory "too expensive". The temperance organizations also showed "very little interest" in the idea. Rosebrugh's personal recommendations were more far-reaching (and thus even less likely to achieve fruition) and were solidly behind the principles of the medical treatment of alcoholism. Rosebrugh's scheme, endorsed by Lett and Crothers, envisioned the appointment of an inspector of inebriate asylums who would be a qualified medical practitioner. He called for a network of provincial hospitals and farm colonies for the "more hopeful" and incorrigible classes of drinkers — adopting a "rational" course of medical treatment. He also advocated the adoption of a probation system for patients after discharge.³³

The lack of enthusiasm with which Rosebrugh's recommendations were met illuminated the basic division between the positions of the medical profession and the temperance movement. For the monumental investment of public monies in an entirely new area of health care

admitted the impossibility of ending drunkenness and eradicating alcohol through prohibition. This neither the government nor the temperance movement was prepared to accept.

The "liquor issue" divided the medical profession. The vogue of alcohol therapeutics coincided with the rise of temperance agitation, resulting in both a useful medicine and a professional embarrassment. Alcohol therapeutics was sufficiently controversial within the profession, both on moral and scientific grounds, to prevent the presentation of a united front to control alcoholism as a medical preserve. At the same time, the views of inebriate specialists met with considerable opposition from temperance advocates. Emphasis on hereditary, congenital and psychological factors was opposed both by pious temperance reformers who believed that individual sin and moral degeneracy were responsible for drunkenness, and also by secular reformers who hoped to use prohibition as the foundation for social change. The differentiation between rich and poor alcohol abusers, an unhappy attempt at reconciling the views of the medical profession with the temperance movement, had little to offer working class and rural adherents to temperance. The disease model of inebriety however did reflect the middle class outlook of the profession and the sympathy with which physicians viewed the opinions of temperance advocates vis-à-vis the poor. Yet personal sympathies proved difficult to reconcile with professional goals such as autonomy. Without the presentation of a united front, the medical profession discovered that not only did it fail to influence public policy, it was forced to defend its own choice of therapeutics.

NOTES

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