not help the forecast in every case. Still, it afforded a great deal of assistance in a large number of cases in giving a tentative prognosis.

Dr. A. R. URQUHART said he would like to add a word to what Dr. Bruce had said with regard to prognosis. In a case to which he referred a young lady had overdosed herself with thyroid for a considerable time, and Dr. Bruce, after an examination of the blood, concluded she was on the high road to recovery, and he proved correct in a very difficult set of circumstances. The tables exhibited represented years of most arduous labour on the part of Dr. Bruce and his assistants, and he was sure no body of men would be keener to give every credit to workers in the speciality than the members of the Medico-Psychological Association. Members were more interested in the results than in the methods; some of them had scarcely time, or inclination, or even ability to prosecute such very difficult and long-drawn inquiries, but the Association included a number of active and willing workers who had demonstrated the value of those methods, and none had done so up to date more than Dr. Lewis Bruce.

A Statistical Note on the Social Causes of Alcoholism.

By W. C. SULLIVAN, M.D., Deputy Medical Officer, H.M. Prison, Pentonville.

THE object of this paper is to draw attention to the nature of the social conditions that lead respectively to drunkenness and to chronic alcoholism, and to point out that these two phenomena are in great measure related to two distinct types of drinking, differing in origin, differing enormously in social gravity, and corresponding to quite different statistical measures.

The two types of drinking referred to may be conveniently distinguished as luxury drinking and misery drinking. By the former is meant the drinking that belongs to relative well-being, temporary or permanent. It will include, for instance, all the forms of convivial drinking, the drinking connected with social and religious celebrations, and the like. Misery drinking, on the other hand, indicates the drinking that goes with conditions of relative ill-being, when what is sought from alcohol is the relief of painful emotional states, or the capacity to react to stresses which the drinker would otherwise feel to be in excess of his powers. This form of drinking, therefore, includes the drinking related to overwork, insufficient or unattractive food, overcrowding, bad hygienic conditions of all sorts. Having regard to what is the chief factor in either variety, we may also describe these opposed forms of drinking as convivial drinking and industrial drinking. To take a concrete instance, the workman who carouses with his comrades on a Saturday night is a type of the convivial drinker; the labourer who, before a

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task which calls for special effort, has to brace himself with a half-quartern of rum, is a type of the industrial drinker.

Of course, in fact these two forms of drinking are frequently combined; the convivial drinker if he eventually becomes chronically intoxicated, is thereby brought to the state of the misery drinker; often indeed the diversion of part of his income to luxury drinking involves a lowering of diet which reduces him in a sense to misery drinking. On the other hand, any momentary improvement in the circumstances of the industrial drinker is for him an occasion, and one which he rarely neglects, to indulge in convivial excess. Such facts do not, however, affect the reality of this distinction; nor do they detract from its value as an instrument of analysis for the examination of statistical data.

Its utility in this latter respect depends on the different relation which the two forms of drinking bear to chronic alcoholism and to drunkenness. Luxury drinking, the drinking that goes with conditions of comparative well-being, is by its nature apt to be intermittent; in countries and classes of low culture it is very likely to run to immediate excess, but its tendency to produce chronic alcoholism is not as a rule very strong. With industrial drinking it is different. It is characteristic of this form of drinking that it goes on during working hours or in the brief interruptions of labour, and further that it is likely to be in substitution of food. It is thus more or less constant in its operation, and therefore tends rapidly and fatally to chronic alcoholism. It leads to drunkenness too, but rather as a secondary result. From a statistical point of view, accordingly, we have two sorts of drunkenness to distinguish—the drunkenness that occurs without chronic alcoholism and indicates convivial excess, and the drunkenness that is associated with chronic alcoholism and is related to industrial drinking.

What makes the matter practically important is, of course, that by far the larger and more serious part of the social evils connected with excessive drinking depend on chronic alcoholism. This is true of racial degenerescence, of insanity, and of suicide; so far as these ills are caused by drink—and its share in their production is admittedly a large one—they are caused by the chronic intoxication. And, though in a less degree, the same thing holds of prostitution, pauperism, and at

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least several of the graver forms of crime. The bulk of the mischief done by alcohol is therefore due to misery drinking, relatively little to convivial drinking. And this is why, as Grotjahn has well shown, alcoholism only attains the proportions of a social problem in modern times, and in countries which provide the conditions of misery drinking, of which industrialism is by far the most important. In antiquity, as in most of the countries of Southern Europe to-day, there is no drink question.

The importance of this distinction of the two radical types of drinking is shown very clearly in the phenomena of alcoholism in England, and the statistical study of these phenomena on which we have now to enter will serve accordingly as at once an example and a justification of our point of view.

As has been already implied, the method of analysis adopted will be mainly the comparison of statistics of drunkenness with statistics which may be taken to measure chronic alcoholism. The chief difficulty is, of course, in regard of the second point. The best index of chronic alcoholism ought obviously to be found in the mortality returns; and though the defective system of death registration gives them only a very qualified value as measures of the absolute amount of alcoholism, they are undoubtedly fairly reliable for comparative purposes, as long, at least, as they deal with sections of the population of pretty similar social standing and are estimated over a sufficient period of time. A more serious obstacle to their use, from our present point of view, is that, as so frequently happens with English statistics, it is impossible to correlate them strictly with other statistical data. In the first place, the registration county which furnishes the mortality returns is not identical with the area of the same name which gives the figures for drunkenness. And, what is a still greater difficulty, there are no available figures for alcoholic mortality for lesser areas than the registration county, so that it is impossible to form composite districts representing special industrial conditions, as can be done in examining drunkenness. This is a serious drawback, for in an inquiry into a phenomenon such as alcoholism the county is, for obvious reasons, a very inconvenient unit. It is necessary, therefore, to have some other test of chronic alcoholism which can be statistically measured, and which can be used to control the mortality figures, and to replace them where they are not

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available. Evidence, which I have elsewhere set out in detail, justifies, I think, the assumption that in this country and at the present time we have such a test in the phenomenon of suicidal attempts. (1) We know, in fact, from clinical experience that in the overwhelming majority of cases these attempts are related to chronic alcoholism; and statistics show that in their age incidence and—as far as ascertainable—in their other characters also, such as their independence of religious influences, they conform completely to the type of alcoholic suicide and differ from that of ordinary suicide. And when we compare, as we shall presently do, the regional distribution of chronic alcoholism with that of suicidal attempts, we shall find therein further evidence of the intimate connection of these two phenomena.

Unfortunately, these statistics of suicidal attempts have one rather serious disadvantage which they share with the mortality returns—both phenomena are represented by scanty numbers, so that slight oscillations, well within the normal ranges, are likely to show in an exaggerated form. This may easily occur, for instance, in the smaller counties, and is probably the explanation of some of the irregular results shown below in Table I. This difficulty is unavoidable; chronic alcoholism, at least as compared with drunkenness, is an infrequent condition, and the phenomena that express it are necessarily on a correspondingly small scale. In 1900, for instance, in England and Wales, while the number of prosecutions for drunkenness amounted to 204,349, the number of cases of attempted suicide was only 1795, the registered deaths from alcoholism were 3638, and from cirrhosis of the liver 4639.

However, if large areas are used, and if a sufficiently long series of years is taken, this source of error is considerably diminished, and conclusions based on these statistical data may be taken as fairly reliable, at all events when concordant with other evidence.

The first series of figures which we have to examine (Table I) gives the rates per 100,000 of the population of (*a*) deaths from chronic alcoholism, delirium tremens and cirrhosis of the liver; (*b*) arrests for drunkenness; and (*c*) attempts to commit suicide in the different counties of England and in North and South Wales. As stated above, the mortality rates refer to registration counties; the other two phenomena have been estimated in relation to administrative counties, which approach more

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TABLE I.—*Deaths from Alcoholism and Cirrhosis of the Liver, Arrests for Drunkenness, and Attempts to Commit Suicide in the Counties of England, and in North and South Wales —Annual Average per* 100,000 *of the Estimated Population in the Decennial Period* 1891 *to* 1900.

	Deaths from alcoholism and cirrhosis of the liver.	Arrests for drunkenness.	Attempts to commit suicide.
Lancashire	25·29	806·4	6·57
Warwick	24·70	599·2	8·56
London with Metropolitan Counties	24·18	748·7	9·43
Shropshire	22·92	661·3	3·36
Northumberland	22·36	1643·8	6·37
Sussex	22·32	312·5	4·78
Buckingham	21·76	97·0	2·80
Cheshire	20·48	546·2	4·72
Derbyshire	20·44	510·1	3·94
Cambridge	19·82	100·6	1·77
Somerset	19·70	246·7	4·67
Hampshire	19·61	390·9	7·82
Worcester	19·50	676·4	5·38
Stafford	18·86	695·4	3·69
Rutland	18·39	153·9	1·49
Nottingham	18·03	541·7	5·85
Westmoreland	18·03	340·8	2·14
Berkshire	17·79	252·6	4·82
Bedford	17·75	184·3	1·80
Huntingdon	17·69	210·0	2·01
York—West Riding	16·67	644·1	4·17
Oxford	16·22	161·5	3·88
Leicester	16·19	261·5	4·62
North Wales	16·07	569·9	1·99
York—East Riding	15·97	620·7	4·55
Durham	15·90	2228·8	4·32
Hereford	15·50	297·8	3·47
Wilts	15·44	172·6	2·62
York—North Riding	15·67	475·7	2·87
Norfolk	15·39	200·7	2·77
Devon	15·38	343·7	4·32
Cumberland	14·92	689·7	2·47
Suffolk	14·61	143·1	2·12
Gloucester	14·41	290·7	4·93
Lincoln	13·85	261·5	4·14
Northampton	13·66	296·4	6·73
South Wales	13·61	1012·9	2·59
Dorset	13·10	209·5	3·69
Monmouth	12·81	629·3	2·22
Cornwall	8·50	230·1	1·11

The Metropolis is here combined in a single area with the counties which contribute to the police district—Middlesex, Surrey, Hertford, Kent, and Essex.

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nearly to the police areas furnishing the returns. This approximate method is the only one available in the muddled state of judicial and administrative regional divisions. In the case of London the figures for drunkenness and attempted suicide are those given for the Metropolitan Police District and estimated in relation to the population of that district. The difference between this area and that of registration London is, of course, so great as to render any comparison of the figures under these heads with the mortality rates quite fallacious as regards both London itself and the counties that contribute to the police district. For our purposes, accordingly, these counties, with the Metropolis, will be treated as a single area. The figures in all cases are the mean figures for the decennial period 1891—1900, and the ratio is to the mean between the census population of 1891 and that of 1901. The counties are arranged in the order of the decreasing frequency of deaths from alcoholism.

Allowing for the sources of error mentioned above, this table on the whole goes to show that, while in the lower figures there is a fairly good parallelism between the three columns, in the higher figures there is much more correspondence between deaths from alcoholism and cases of attempted suicide than there is between either of these phenomena and arrests for drunkenness. The exceptions to this tendency are chiefly small counties where the results are, of course, least reliable. And it will also be observed that the divergence between the frequency of drunkenness and the frequency of deaths from alcoholism and of suicidal attempts is most marked in counties where the rate of drunkenness is high. The mining districts show this particularly well. The most important of them—Durham, Northumberland, and South Wales—form a special group at the top of the list for drunkenness, showing annual rates of 2228·8, 1643·8, and 1012·9 respectively. But in the scale of alcoholism Durham and South Wales rank very low, Durham, far and away the most drunken county in England, being in the fourteenth, and South Wales in the fourth place from the bottom. Northumberland appears to be an exception, and ranks high under all heads, but it is really an exception which proves the rule, for its anomalous position is entirely due to the dominant influence of Newcastle, which contains over 37 *per cent.* of the population of the county, and which, as a seaport, presents quite different industrial conditions. If New-

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castle be excluded, the rate of drunkenness still remains at 1384·8 per 100,000, but the rate of suicidal attempts falls to 3·30, which is but little above the ordinary level in mining districts.

It is, therefore, evident from these figures that not only do drunkenness and alcoholism not coincide in distribution, but there is even a tendency for the maximum of drunkenness to occur with the minimum of alcoholism. A clearer view of the facts is gained when, instead of the counties with their mixed industrial conditions, we take composite areas formed by uniting districts where these conditions are similar. For this purpose we may adopt the selection made in the criminal statistics, where the representative regional groups are made up as follows :—

Agricultural counties (county police districts only).—Norfolk, Suffolk, Hunts, Cambridge, Dorset, Hants, Somerset, Wilts.

Manufacturing towns.—Birmingham, Blackburn, Bradford, Derby, Halifax, Hanley, Huddersfield, Leeds, Leicester, Nottingham, Oldham, Preston, Sheffield, Wolverhampton.

Seaports.—Birkenhead, Cardiff, Hull, Liverpool, Newcastle-on-Tyne, Newport (Mon.), Southampton, South Shields, Swansea, Tynemouth.

Mining counties.—Derbyshire (excluding Derby borough), Durham (excluding Hartlepool, South Shields, and Sunderland), Glamorgan (excluding Cardiff and Swansea), Monmouth (excluding Newport), Northumberland (excluding Newcastle and Tynemouth).

In this part of our analysis, as has been already stated, mortality statistics fail us, so that we have to fall back on the rate of suicidal attempts as our index of chronic alcoholism. We can, however, utilise the mortality returns in an indirect way to test the accuracy of this index in its present application, by comparing the incidence of suicidal attempts in the several composite areas with the death rates from alcoholism in the corresponding occupational groups. This method works well where the regional group has a close equivalent in a single occupational group, as is the case with the agricultural and mining districts. But it is naturally of less value in dealing with the manufacturing towns, and *à fortiori* with the seaports, where the more complex conditions do not admit of being approximately represented by one definite industrial class. In these latter cases, therefore, it is only possible to make a partial application of the method by singling out such of the

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occupational groups as may seem most characteristic of the special industrial conditions in each area, *e.g.* in the manufacturing towns the great groups of the textile and metal workers, in the seaports, the dockers.

Table II, then, shows the rate per 100,000 of the mean intercensal population of (*a*) arrests for drunkenness, and (*b*) attempts to commit suicide, in the several composite groups formed as above. And, as a check on our assumption that the incidence of the second phenomenon corresponds with that of chronic alcoholism, Table III, which should be read with Table II, gives the comparative mortality figures from chronic alcoholism alone, and from chronic alcoholism and diseases of the liver taken together, in the chief occupational groups according to the census of 1891; the figures are practically the same in the earlier returns. A diagram shows the substance of the tables in graphic form.

TABLE II.—*Prosecutions for Drunkenness and Suicidal Attempts in Composite Areas of Special Industrial Character (Annual Average per* 100,000 *of Estimated Population during the Years* 1891—1900).

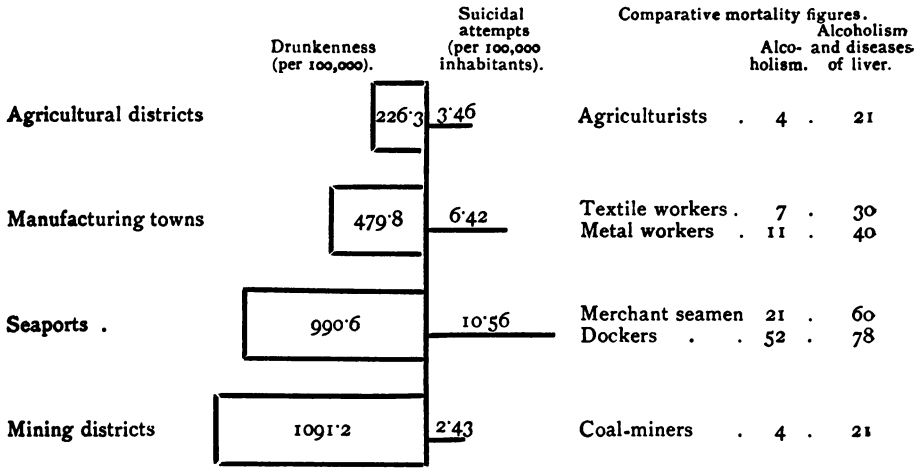
	Drunkenness.	Suicidal attempts.
Agricultural counties	226·3	3·46
Manufacturing towns	479·8	6·42
Seaports	990·6	10·56
Mining counties	1091·2	2·43

TABLE III.—*Comparative Mortality Rates from* (*a*) *Alcoholism and* (*b*) *Alcoholism and Liver Diseases taken together, in the Larger Occupational Groups* (*Census of* 1891).

	Alcoholism.	Alcoholism and liver disease.
Agriculturists	4	21
Coal-miners	4	21
Railway engine-drivers, etc.	4	22
Textile manufacturers	7	30
Quarries, etc.	8	23
Shoemakers	9	29
Railway labourers	10	27
Metal workers	11	40
Bakers	11	50
Tailors	12	43
Shopkeepers	14	43
Messengers, porters, etc.	15	31
Carmen, carriers	17	44
Merchant seamen	21	60
Coach and cab service	28	61
Butchers	35	91
Dockers	52	78
Publicans, etc.	94	268

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Diagram showing the Relation of Drunkenness and Alcoholism in the Composite Areas representing Special Industrial Conditions.



Examining these tables, then, we find that they repeat, but in a clearer and more definite way, the results suggested by our comparison of drunkenness and alcoholism in the counties. More particularly they confirm the view that these two phenomena are in a very large measure independent. Thus it will be noted that while the agricultural and mining districts present respectively the minimum and the maximum development of drunkenness, they nevertheless appear practically equal in regard of alcoholism, from which both are relatively free: in both, in fact, the rate of suicidal attempts is very low, and the comparative mortality figures from alcoholism of coal-miners and of agriculturists is the same, and is lower than that of any other industrial group.

Now we can most clearly interpret these results by taking as our guide the distinction already pointed out between the two fundamental types of drinking. In the agricultural districts the conditions of life do not specially favour either luxury or misery drinking: though the labour is badly paid and arduous, it is done in the open air, does not demand sudden spurts, does not involve the bad hygienic surroundings that beset the slum-dweller of the towns; therefore there is relatively little industrial drinking. On the other hand, there is small margin for convivial excess. Naturally the relative remoteness of the public-

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house in a thin and scattered population discourages both forms of drinking. Under these circumstances, therefore, we find that in the agricultural counties drunkenness and chronic alcoholism, as measured by suicidal attempts, are both rare, and the death-rate of agriculturists from alcoholism and from liver disease is a minimum.

In the mining districts we have to do with a well-organised, well-paid form of labour: wages are high, employment tolerably steady, hours of work relatively short, hygienic conditions fairly good, and—a most important matter—there is little female labour, so that the women are able to look after the feeding and home comforts of the family. All the circumstances, therefore, are against misery drinking. On the other hand, this relative well-being in a population of low culture is certain to produce convivial excess. In these mining districts, accordingly, we see an enormous development of drunkenness, greater indeed than is reached in any other part of the country. But, on the other hand, we find a minimum of chronic alcoholism: the mortality of coal-miners from alcoholism alone and from alcoholism and liver disease together is the same as that of agriculturists, and the rate of attempted suicide is even lower than that in the agricultural districts.

In the manufacturing towns we have to do with conditions of labour which are necessarily very mixed, but which, taken in the average, compare unfavourably with those in the mining districts. In most of the trades the workers are less well organised, hours of labour are longer, the hygienic conditions during work and in the homes of the workers are inferior, and there is a large amount of female labour with its attendant disorganisation of family life. All this makes for industrial drinking; and, partly from the same reasons as in the mining districts, and partly because misery drinking necessarily leads to a secondary development of luxury drinking, the convivial form is also well marked. In these towns, therefore, we find a rate of drunkenness which is fairly high, though still less than half that in the mining districts, and we find a rate of attempted suicide which is very high, nearly three times that in the mining counties, and correspondingly we find that the comparative mortality figures for alcoholism in such large groups, for instance, as the textile workers and the metal workers, are respectively nearly two and three times as high as in the group of coal-miners.

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Finally, when we come to the seaports we have to deal with the least favourable conditions of labour. Besides the merchant seamen, whose mode of life and traditions do not make for temperance, there is in these towns a large infusion of unskilled casual workers whose occupation demands sudden spurts of muscular effort, whose housing conditions are bad, whose pay is low, whose work is irregular, and at times excessively prolonged. Moreover, there are no restrictions on the constant drinking of this class of labourer, such as the employer imposes during working hours on men who have to do with machinery. Further, the seaports have a large element of women engaged in prostitution, a form of industry which strongly tends to misery drinking. In the seaport towns, accordingly, while drunkenness, though very rife, is still a little below the level of the prosperous mining districts, chronic alcoholism, as indicated by the frequency of suicidal attempts, reaches an enormous development. The occupational death-rates are of less use to us here, as there are fewer groups which can be taken as specially representative of seaport life; two such groups, however, there are, namely the merchant seamen and the dockers, and both rank high in the alcoholic scale, the latter indeed showing a death-rate from alcoholism which is surpassed only by the liquor trade group. Of course, it may be objected that dock labour and similar forms of unskilled work are the refuge of the unfit, and that therefore some proportion of the men who drift into this sort of life do so because of drunken habits acquired elsewhere, or because they are of the shiftless and incompetent type who readily become drunkards. And this objection undoubtedly contains part of the truth. None the less the analogy from the rise of alcoholism with the deterioration of industrial conditions in the various groups of skilled labour suggests very strongly that a similar agency is responsible, to some extent at all events, for the continued rise in these classes of unskilled labour.

The divergence between chronic alcoholism and drunkenness which is so striking in the regional distribution of these phenomena, is for obvious reasons less apparent in their periodic variations. It is, however, traceable at times in a want of correspondence between the movement of drunkenness and the movement of other social facts which are known to be more or less importantly related to alcoholism. An interesting instance

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of this sort is pointed out by Sir John Macdonnell in his admirable introduction to the Criminal Statistics of 1899. He observes that though the year was a record one for drunkenness, the prosecutions for that offence being 15 *per cent.* higher than in the preceding quinquennial period, "there was at the same time a decrease in crimes of violence and other offences which might be supposed to be intimately connected with drunkenness." "It was," he further remarks, "a year of great prosperity; a year in which failures were the fewest during the previous decade; in which the Revenue showed a large surplus; in which wages advanced, and in which there were exceptionally few strikes." "On the whole," he adds, "it would appear that for the present drunkenness is apt to be a concomitant of high wages and good trade." We may probably infer from these facts that it was at all events in part because the increased drunkenness of 1899 was mainly due to luxury drinking that it did not lead to an increase in homicidal crime, which is on the whole more dependent on the chronic intoxication.

It is, of course, chiefly in its bearing on the question of prevention that this view of the social causes of alcoholism has most practical interest. The distinction between convivial and industrial drinking being essentially one of origin, it obviously implies a corresponding difference in the methods suited to deal with either form.

Primary convivial excess is, in the first place, very much more curable; it belongs to the effervescent time of life, and not uncommonly subsides spontaneously with maturer years; its age-curve approximates pretty closely to that of other expressions of the expansive tendency, such as crimes of acquisitiveness. Its prevalence depends, too, in a large measure on social ideals and customs, and therefore changes with the degree of culture and can be modified by educational and religious influences. The sobriety of the educated classes in this country at the present day as compared with their drunkenness in the eighteenth century is a familiar example of such a progress in manners.

With industrial drinking it is entirely different. So far from having any tendency to spontaneous arrest, it is usually aggravated by advancing age. And not only is it not amenable to the moral and educational influences that can control luxury

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drinking, but, when brought into previously sober communities, it weakens or destroys the efficacy of such influences, so that *pari passu* with the spread of chronic alcoholism and its usual results, there comes also a growth of convivial excess. Thus, for instance, in Northern Italy (2) and in parts of Spain (3) within recent years, the introduction of industrialism has been accompanied by a rapid development of alcoholism, an increase in alcoholic insanity and alcoholic crime, and in drunkenness, in strong contrast with the traditional sobriety of the nations of the Latin culture.

The consideration of such facts as these may perhaps be useful in preventing exaggerated estimates of the possible effects of "drink cures," medical or legal, on the alcoholism of a nation.

Summary.—In conclusion we may sum up the results of our inquiry in the following propositions :—

1. In considering the social causes of intemperance, which are by far the most important, it is necessary to distinguish two opposed types of drinking, *viz.* the drinking that goes with conditions of relative luxury, and finds its most frequent expression in ordinary convivial drinking, and the drinking that goes with conditions of relative misery, of which bad industrial circumstances are the most considerable factor.

2. Convivial drinking may, and often does lead to drunkenness, but, at least in its pure form, does not tend very much to chronic alcoholism. Industrial drinking, on the other hand, while leading also, though less immediately, to drunkenness, tends rapidly and fatally to chronic intoxication.

3. From a statistical point of view, therefore, while chronic alcoholism always implies the existence of drunkenness, drunkenness by no means implies the existence of chronic alcoholism. In England this divergence between the two phenomena is best seen in the prosperous mining districts, which by reason of their prosperity are at once more drunken, but less alcoholic, than any other part of the country.

4. The graver social evils that are in any important degree caused by alcohol are related to the chronic intoxication, and are, therefore, mainly due to industrial drinking.

5. While educational, religious, and similar influences can control the excesses of convivial drinking, they have but little action on industrial alcoholism, which can only be checked by

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raising the standard of living, and, in a minor degree, by such methods as restricting the facilities for obtaining alcohol during work hours, providing hygienic substitutes, and so forth.

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Discussion

At the Quarterly Meeting in London, May 18th, 1904.

The President remarked that Dr. Sullivan had made a very interesting contritribution, and he was sure there were several members present who would wish to discuss the paper.

Dr. Stewart (Clifton) said there was no doubt that the general public had for many years been in the habit of confounding the two terms drunkenness and inebriety, and the Society should set its face against this practice. A large number of cases of drunkenness were looked upon as cases of disease, and so labelled, and afterwards, when the drunkards gave up their vicious habits, they were spoken of as having been cured of the disease. This was a dangerous thing; it was dangerous to lead people to believe that those who were diseased had been cured by, for instance, the gold cure, or atropine, or any other drug; the fact being that those who were cured were instances not of inebriety, but of drunkenness—people who had a pernicious habit of drinking, but whose habit had not produced that pathological condition which he would be glad to find every medical man associating with the term inebriety. He asserted that people might go on for years as drunkards and yet not have the brain disease which was the only thing to justify one in speaking of such persons as inebriates. With regard to the author's classification into luxury drinking and misery drinking, he thought that a very happy nomenclature, and that it would help one very often to account for many cases which came under one's notice. He (Dr. Stewart) had tabulated a list of 200 cases of inebriety which he had had under care, and found that 124 of those 200 had been due to misery. He thought the reason was that a large proportion of his cases had occurred in ladies. He considered there was more disappointment amongst women than amongst men, in regard to certain circumstances in life. Women did not like to show their trouble, and therefore took something which would assist them in concealing it. The Society was under a deep obligation to the writer of the paper for the manner in which he had presented a number of interesting facts.

Dr. Mercier said he rose not so much to criticise the paper, which afforded a very great deal of material for remark, as to offer a practical suggestion. A paper such as that, which contained so much food for reflection, could not be adequately discussed after merely hearing it read, and if the papers brought before the Society could be circulated in proof before being read, so that members might have the opportunity of preparing their criticisms, the debates would have more value than they at present possessed. He, like Dr. Stewart, had been much interested in the distinction drawn by the author between "luxury drinking" and "misery drinking." He was not prepared at the moment to either agree or disagree with it; but if it were a true distinction it must profoundly affect all one's thinking about alcohol in future, and must modify one's notions, both as to the cause and as to the remedy of the condition.

Dr. Hayes Newington said there was one causal factor in alcoholism which appeared never to be considered when those matters were discussed. People were

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very apt to go off to the social, moral, and psychological aspects, and altogether forget to speak of the quality of the material which was put into the body. Attention should be bestowed on the vile stuff which was imbibed by people, some of whom possibly would not be drunkards if they had good instead of bad liquor. He did not see how alcoholism could be discussed adequately without taking that into consideration. It seemed to his mind nonsense to talk about restricting the number of licensed houses and imposing parliamentary limits so long as men were unrestrictedly allowed to go on poisoning his Majesty's *lieges*. One had only to refer to the *British Medical Journal* of a few months ago to find that merely a percentage of distillers relied on malt altogether for the manufacture of whisky, and that the greater part of the stuff sold as whisky was silent or patent spirit. How could people go on putting fiery stuff into their vessels without suffering some material damage? Was there any other way in which people were allowed to poison themselves without any consideration of the mischief which was thus being wrought? Turning to the evidence which was given at Marlborough Street a few weeks ago, it was stated that there was no test for brandy, and that seemed to be the case with beer and other liquids. It was said that a standard test of beer could not be made, but one would think that some of the analytical chemists would have been bold enough to advise what material should not be found in liquors. Some years ago, when the Association considered the question of making reports on various subjects, and especially statistics on alcoholism, he suggested there might be something instructive in the comparison between districts where the people drank beer and those in which the chief stimulant or beverage was spirits. Obviously there must be a considerable difference between the mental condition of a man who for years fuddled himself every day of the week with small beer, and the man who got furiously drunk every day of the week with a strong and noxious poison. His object in rising was merely to suggest that the matters he had referred to must be taken into consideration when weighing the material parts of Dr. Sullivan's valuable paper.

Dr. DAVID YELLOWLEES said he had listened to Dr. Sullivan's paper with very great interest and appreciation. He appreciated the distinction between convivial drinking and misery drinking, but it by no means covered the ground. There was certainly a large class of drinkers who did not need the excuse of conviviality, and had not the excuse of misery, but who drank because they liked to drink. One point on which he desired to have a clearer definition was the term which was used so frequently in the paper—"Chronic alcoholism." What did that mean? With most students of the subject, he thought it had come to mean chronic alcoholic degeneration of the organism, the brain included. But evidently that was not the sense in which it was used in the paper, and it should be stated in what sense the term was used. If the writer meant by it simply habitual and constant indulgence, let it be so understood. Convivial drinking happened in different classes of people, and at different periods of life, and was not so apt to lead to ruinous drinking; misery drinking happened at a time of life when the misery still remaining, the drinking went on. Alcoholic suicide associated with chronic alcoholic degeneration was, he thought, rare; but there was a form of chronic alcoholism in which suicide was common. He was sure a definition of terms was necessary before one could appreciate the paper as it deserved. He had listened to it with great pleasure, and would be glad to see it in print.

Dr. G. F. BLANDFORD said that there was a great deal in what Dr. Yellowlees had said as to the necessity of the terms used being more strictly defined. He thought there were a number of chronic alcoholics who did not always drink, who had periodical bouts of drinking, and who between those bouts drank but very little. Those, he considered, were quite distinct from convivial drunkards, and those who, as Dr. Yellowlees said, drank because they liked it. But he thought they were a much more serious form even than continual drinkers, and much more difficult to cure. He added that carefully compiled statistics of the various types would prove valuable.

Dr. BRANTHWAITE remarked that the point which had already been mentioned affected a large part of Dr. Sullivan's paper, namely, the distinction between drunkenness and chronic alcoholism. He had had something like twenty-two years' experience, and during that time he had done nothing but treat drunkenness, and at the present time he had two or three thousand patients under care. But he

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did not yet know which was a drunkard and which was a chronic alcoholic. Perhaps Dr. Sullivan would tell him in his reply.

Dr. GEORGE H. SAVAGE said he quite realised that statistics had to be met by statistics, and he had no statistics to offer. Undoubtedly knowledge increased by the collection of statistics, even though it was said that statistics could be turned to any use. One of the most important things which had been ventilated in the discussion was that by Dr. Hayes Newington, that the classes of cases could not be compared unless one knew the composition of the liquids which were being imbibed. He had recently spent three weeks in Italy, where he saw a great deal of wine-drinking, but during those three weeks he did not see one man really drunk. Yet he believed a very great deal of brain disease and mental disorder generally were produced by the drink they took. It was very important, as previous speakers had said, to be exact in definitions of drunkenness, inebriety, and chronic alcoholism. There was drink as a symptom, and drink as a cause, and there was drink as both symptom and cause. But the cases which mostly came under the notice of alienists were the recurrent ones. They might be sometimes classified with misery drinkers when the period of depression was associated with the period of drink, but such persons did not drink because they were miserable, but because it was a stage of the mental disorder through which they were passing.

Dr. ROBERT JONES wished to join in thanking Dr. Sullivan for his extremely suggestive paper. One of the most interesting questions was, Why do people drink? Dr. Sullivan had classified them into a misery and a convivial class, but he (Dr. Jones) thought it was the same cause in both, always some cause which made the heart of man glad and tended to kindle a better feeling than he had been experiencing before. He regarded the classification of misery and convivial drinking as somewhat artificial, for the miserable man wanted to change his emotional *status*, and so did the convivial man. There was no doubt that the intervals in the police cell tended to make the chronic drinker a periodic one, and also perhaps prevented his becoming a chronic alcoholic. He (Dr. Jones) thought restrictive legislation was very important in the matter of controlling drunkenness; he believed we could make both man and woman sober by Act of Parliament, as witnessed by the results of the Sunday Closing Act in Wales. It was, however, too late to raise new points.

Dr. SULLIVAN, in reply, said—The chief criticisms to which I have to reply refer to terms and definitions, and more particularly to my use of the terms chronic alcoholism and drunkenness. These criticisms, I venture to think, are based on a certain misconception, due, no doubt, to my too rapid reading. This is a statistical paper, and therefore I have had to take the terms and facts as I found them; I have no responsibility for the choice of the terms and no authority to define them otherwise than according to their plain sense. Thus "chronic alcoholism" is a heading used in the mortality returns of the Registrar-General, and "drunkenness" a heading used in the Criminal Statistics. I imagine that what is present in the mind of most persons who register deaths as due to chronic alcoholism is the chronic alcoholic degeneration of which Dr. Yellowlees speaks—contrary to Dr. Yellowlees' impression it is certainly what I mean when I use the term on my own responsibility. But be that as it may there can be no doubt that by the registration of deaths under this rubric it is at least meant to convey that the individuals died of alcohol, so that these figures plainly express the drinking that leads to the cemetery; just as "drunkenness," the heading in the Criminal Statistics, expresses the drinking that leads to the police cells. And the whole point of my paper is that these two sorts of drinking are so different that in this country where you have most of the latter you have least of the former. The distinction, therefore, between drunkenness and alcoholism is not, as Dr. Branthwaite supposes, a distinction invented by me; it is a bald statement of fact. The question of the relation of suicide to chronic alcoholism is too large a matter to go into now; but I may venture to point out that Dr. Yellowlees' opinion is, I think, rather at variance with general experience. The very inventor of the term chronic alcoholism, Magnus Huss, repeatedly mentions suicidal tendency as a specially frequent symptom in these cases; and most other writers on the question have agreed with him. Personally, I hardly know half-a-dozen "Black-Listers"—at least of the Black-Listers who are really chronic alcoholics—who have not made one or more automatic suicidal attempts in their career.

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