



Seeing Addiction
A Personal Memoir

Griffith Edwards

Edited by Thomas F. Babor

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Foreword by Jerome Jaffe
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Foreword

Jerome Jaffe

Griffith Edwards was much loved and deeply respected by all who knew him. Honored by universities, learned societies, and governments throughout the world, he was the founder and for many years director of the Addiction Research Unit at the Maudsley Hospital's Institute of Psychiatry, which under his leadership became Britain's National Addiction Centre. He was the first named Professor of Addictive Behaviour at King's College London, a title created specifically for him.

I first met Griff in 1970 when he asked me to join him in London to write a "Working Paper" for the World Health Organization (WHO) Expert Committee on Drug Dependence. That meeting led to a warm and enduring friendship ending only with Griff's death in 2012. The Working Paper we produced (1) introduced me to Griff's concept of a national response to the use of psychoactive drugs.

"By positive action (or, more often, by inaction) a nation responds to the fact that particular psychoactive drugs and that nation's

people co-exist. The response is astonishingly multifaceted – sometimes purposeful – at times, accidental. All of the elements making up the national response – treatment of drug users, attempts to control drug availability or commercialization, and official regulation of drug consumption – are always in a state of dynamic equilibrium. The legislator or planner who pulls or pushes just one lever may find that he has set in motion a train of inter-reacting processes; new balances are struck, unexpected and sometimes untoward events occur.” (1, p. 3)

Little did I dream that shaping a national response for the U.S. would later fall in part to me when, within the year, I was appointed Special Consultant to the President for Narcotics and Dangerous Drugs (dubbed the first “drug czar”).

Griff’s interests in the problems of addiction had no boundaries. He made seminal contributions to treatment, epidemiology, history of addiction, the nature of the addictive process and its natural history, teaching and communicating the science of addictive problems, and policy, including the role of governments in dealing with alcohol and drug use. He believed passionately in the importance of the role of science in shaping national policies but was wisely aware of the frictions that can arise. Here is Griff in the opening pages of a 1987 Royal College of Psychiatrists report:

“To talk of “co-existence” is not to preach cynicism or a tired *laissez faire*. The true message is very positive. It is the insistence that there exists a responsibility to evolve the best co-existence possible for the present moment, with everything that is done informed by a sense of history, by a keen appraisal of the facts, by a reflective awareness of current value systems, and by a mature and balanced judgement of what is or is not possible.

“Drug problems will not be beaten out of society by yet harsher laws, lectured out of society by yet more hours of “health education”, or treated out of society by yet more drug experts” (2, p. 2).”

And, in a 1991 conference on policy at the National Addiction Centre:

“... It is self-evident that politics is about multiple trade-offs, but within the context of that evidently complex process it is the job of the scientific community fearlessly, resolutely, and persistently to present the truth as best it perceives that truth, with due admission also of ignorance. More daringly still (and with consequently large possibilities for arrogance and betrayal), science is not just about increasing the sum of knowledge but is also concerned with the cherishing and transmission of certain very precious values relating to rationality, integrity, daring to question, and not being bribable. Science does not win its arguments in a day, its findings may often be awkward, but Galileo is more memorable than the papal policy makers who forced his recantation. ...” (3, p. 36).

In 2013 I had the honour of speaking at a memorial celebration of Griffith Edward’s life and work. After offering a few excerpts from his writings, I expressed the hope that his unique voice be long heard talking to us across space and time. That hope has now been made tangible with the publication of this collection of Griff’s writings, skillfully and lovingly edited by Professor Tom Babor, one of Griff’s most distinguished colleagues, and Jean O’Reilly. Anyone who has even a passing interest in the way alcohol and other psychoactive drugs interact with our lives or with the evolution of the field of addiction science will be enriched by reading this book.

Jerome H. Jaffe, M.D.

Former Special Consultant to the President for Narcotics
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Special Office for Drug Abuse Prevention (1971–1973)

Former Director, NIDA Addiction Research Center (1984–1989)

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Preface

Thomas F. Babor

It is a very humbling experience to be charged with the editing of Griffith Edwards's (1928–2012) last book. As his health continued to fail during his final two years, his mind became increasingly focused on the quest he had begun many years ago to find in the study of addiction the answers to some of life's most persistent questions. Despite living most of his life in the rarefied world of academic medicine, Griffith had many personal and professional experiences that enabled him to see addiction from a variety of different perspectives, and in doing so they opened up the doors of perception into an inner world he had struggled with himself.

Work on this book began in earnest in 2012 when he began dictating large amounts of material for transcription, organized according to the chapter titles of the first part of the book. Griffith reviewed and edited most of the chapters himself, but several were left in a rather rough dictation that required a considerable amount of fact-checking and text editing. The second part of the book was finished before the first because it consists of travelogues that were written and published over the course of his career or

were recorded in his copious diaries in a form that required little additional editing.

With end stage renal failure, Griffith knew that time was short, and that gave him the energy to put most of the book's content into an editable draft. Soon after his death his widow, Susan Edwards, asked me to determine if the draft chapters were sufficiently complete to bring the project to fruition. They were, but for a variety of reasons the project languished for several years, in part because of what I can only refer to here as the dilemma of the editor's editor. How do you edit a book written by one of addiction's most prolific authors and one of its most influential journal editors, when that person is no longer there to provide guidance and encouragement? I struggled with this dilemma until the force of his message made it impossible not to finish the task in a way befitting the spirit of his last contribution to addiction science. Part of the impetus to bring the book to publication came from the very students of addiction for whom the book is written. While it is true that Griffith wanted to share his recollections of the inner workings of addiction science with friends, colleagues and the invisible college of addiction researchers, he was particularly interested in the next generation of addiction scientists. He knew that good books can inspire young people to carry on the quest begun by others, so he tried to make this book as inviting and as welcoming as possible to students and professionals in training.

As these chapters were being edited, they were shared with masters and doctoral students taking graduate courses at the University of Connecticut in the United States and at Charles University in the Czech Republic. It became clear from students' discussions of the chapters that the ethical, historical, clinical, political and interpersonal issues considered in this memoir resonated with aspiring addiction scientists, and were capable of bridging the gaps not only between generations but also between cultures.

The emergence of modern addiction studies as a viable interdisciplinary academic endeavour is a tribute to the life of Griffith Edwards, and the role he played in advancing addiction science. I can therefore think of no better way to close this Preface than with

a quotation from an interview conducted with Griffith Edwards in 2005 (1, p.17). This was his response to a question asking for his advice to young persons “who are entering the field and hoping for a fulfilling career”:

“I have always dreaded the day when I would be answering that question rather than being the young person. Seek out good teachers. Make a happy marriage (with Sue I have been singularly fortunate). Kind children can be very life-enhancing (Dan and Rosie). Keep friendships in good repair. Your work matters, but find time to enjoy the conversations on the lawn.”

Thomas F. Babor, Ph.D., MPH, DHC
Professor Emeritus, University of Connecticut
School of Medicine

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This book owes a huge debt of gratitude to a number of people and several organizations, without whose selfless efforts its contents would have been lost in cyberspace.

First, Jean O'Reilly was responsible for the transcription of audiotapes that were dictated by Griffith Edwards in 2012, and she proved to be a critically important institutional memory when it came to deciphering what the author said, what he meant and what he intended to be done with the manuscript. Jean's work was supported initially by the journal, *Addiction*, and subsequently she volunteered her time to help with the copy editing and error checking prior to publication.

Susan Edwards was invaluable as well. Not only did she entrust the rough manuscript to Tom Babor in 2013 with a polite request to evaluate its potential value, she also conducted a careful review of its edited contents to make sure it was as accurate as possible and represented her late husband's last wishes. Daniel Edwards, Griffith's son, was another member of the family who contributed to the final editing by supplying some of the photographs that were used to illustrate the chapters.

Colin Drummond provided valuable comments on the people described in Chapter 1, and Jerry Jaffe was just the right person to write a Foreword from the perspective of a friend and colleague.

Charles University and the University of Connecticut played critical roles in the publication of this manuscript. The Department of Addictology, part of the First Faculty of Medicine at Charles University in Prague, helped to evaluate its training potential by using it in the medical school's PhD program in addiction studies. Special thanks are due to Professors Miroslav Barták, Michal Miovský and Roman Gabrhelík for their support and encouragement of this project, and to the US National Institute on Alcohol Abuse and Alcoholism, which provided a grant (R25AA024435) for the development of a Graduate Certificate in Addiction Science, which includes a course that is based in part on the book's chapters.

Finally, the publication of this book would not have been possible without the advice of Denise Parris, Lisa Parenteau and Christopher Connors at UConn Health, who found a way to leverage the funds and navigate the complex copyright and financing challenges that eventually brought closure to the contract between UConn Health and Ubiquity Press.

If the publication of this book required more than a decade of intermittent efforts to bring it to fruition, those efforts are a small piece of the debt we all owe Griffith Edwards for the vision he shares in *Seeing Addiction*.

EDITOR'S INTRODUCTION

Seeing Addiction through the Eyes of a Visionary

Thomas F. Babor

The Eyes of a Visionary

Visionary is a word that conjures up images of a person with original ideas about what the future will or could be like. Such a person is likely to be imaginative, creative, inventive, insightful and wise. Sometimes visionaries are considered to be impractical, unrealistic, and out of touch with reality as well. Griffith Edwards (1928–2012) was a visionary who epitomized all the qualities in the first part of the definition, without any of the impractical dreamer qualities of the second.

To those who knew him from his reputation, he was the originator of the alcohol dependence syndrome concept, the debunker of the controlled drinking controversy, the inspirational leader of the UK National Addiction Centre, the longtime editor of the journal, *Addiction*, the author of numerous books, and the always iconoclastic voice on the lecture circuit. To those who knew him personally, he was more than his reputation, which did not mean much to him except perhaps as an instrument for promoting addiction science in the service of the public good. As a friend,

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scholar, mentor and thought leader, Griffith Edwards was one of the most influential figures in the modern history of addiction science. He challenged the status quo, pushed the envelope of critical thinking, demonstrated compassion for addicted patients, questioned conventional wisdom, promoted research integrity, translated research into policy, and most of all, created institutions that continue to change things for the better.

What does the reader need to know to benefit from and enjoy this book? Readers need to know something about Griffith Edwards, and that this was his last book. So a bit of biography will provide the necessary background before describing how this book serves as his own autobiography.

Early Life

James Griffith Edwards was born in Muktesa, India on 3 October 1928. His parents, James and Constance, had moved there in 1923 because of his father's work as a veterinary bacteriologist. The family returned to Wales in 1929. His father produced the first active immunization against rinderpest, and later received the Order of the Nile for his work in Egypt against an outbreak of that same bovine infection. After the separation of his parents in 1934, his early years were spent with his mother in a small Hampshire cottage with no main water, electricity or central heating until after 1945. His mother educated him at home until he was ten, when he was sent to Andover Grammar School. At age 17 he won a County Major scholarship in mathematics and at 18 he gained a place at Oxford's Balliol College. He first read maths and physics but soon switched to medicine.

In 1948 he passed preliminary exams and then went off to complete National Service, which quickly brought him to officer training school. Throughout this period he became acutely aware of the role of social class in post-war England, and his ambiguous place in it. Influenced by his father's commitment to science and his mother's humanism, he resolved to specialize in psychiatry when he returned to medical school in 1949. Besides the lasting friendships he formed at Balliol, he was elected to the Arnold debating

society, which provided valuable experience for his later career as a promoter of ideas and a persuasive polemicist. St. Bartholomew's Hospital, which he chose for his clinical training, reminded him of his distaste for class distinctions and authority figures. His iconoclasm, expressed in his editorial and satirical writings in the hospital journal, of which he was editor for a short time, left him without a job at the end of his clinical training.

He did a 3 month postgraduate course at the Hammersmith Hospital in West London, paying his own way and being offered a house job there. He was then accepted for training in psychiatry at the Maudsley Hospital. He described his early years there as the "Balliol experience reprised," meaning he was back in the world of ideas, science and the search for answers. Under the leadership of Aubrey Lewis, the Maudsley at that time was emerging as the science base for British psychiatry, a place that was also becoming an international centre of clinical innovation, scientific creativity and the new paradigm of social psychiatry.

Addiction Research Career

Attracted to research and writing, in 1960 he published his first paper, on the hypnotic treatment of asthma (1). Later he would say that he was drawn to the study of addiction through a combination of luck, mentoring, and the challenge of applying science to the study of patients whose lives he could empathize with. Other research projects followed with publications on Skid Row alcoholics (2) and the counterintuitive finding (3) that there were no differences in treatment outcomes for patients assigned randomly to either inpatient or outpatient programs for persons with alcohol dependence.

The emergence of a heroin epidemic on the streets of London in the mid-1960s persuaded the UK Medical Research Council (MRC) to set up a research capability at the Maudsley Hospital's Institute of Psychiatry. Edwards was seen as a rising star who could direct clinical and epidemiological research and develop innovative treatment programs. MRC funding and his persuasive powers attracted bright young professionals from a variety

of disciplines to the newly formed Addiction Research Centre, where they conducted research on the full spectrum of addiction, including alcohol, tobacco and other drugs. He traveled widely, observing how different countries dealt with drug and alcohol problems, and developed close relationships with colleagues all over the world.

His research spanned the boundaries of epidemiology, clinical trials, health services, ethnography, history and health policy. He was a pioneer not just in the design of crucial clinical experiments, but also in the promotion of research at the level of the interdisciplinary research team and the multidisciplinary research center. He liked working with people, especially people who brought to the table simple questions, new methods, creative interpretations and a skeptical outlook.

His 1976 paper with Milton Gross (4) describing the Alcohol Dependence Syndrome became a classic theoretical piece for a field looking for a clear clinical description around which to organize research and clinical practice. The paper re-defined what was previously included under the more ambiguous term alcoholism, postulating at its core the development of an overwhelming need to ingest large amounts of alcohol. The key elements of the syndrome, subsequently verified by other clinical and biological scientists, included impaired control over drinking, the narrowing of the drinking behavior repertoire, changes in neurocognitive functioning, subjective craving for alcohol, tolerance to its effects, a characteristic set abstinence symptoms and the prioritizing of alcohol over all other pursuits and pleasures. Edwards' publications on the dependence syndrome and related concepts (4–7) were used by the World Health Organization (WHO) as the basis for the 10th revision of the *International Classification of Diseases* (8) and were incorporated into the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in its 1987 and 1994 editions (9, 10). The dependence syndrome concept has also been applied to other addictive substances such as nicotine, opiates, cocaine and sedative-hypnotics. The syndrome concept of addiction has had a profound influence on the way

addiction is conceived, treated and prevented, even as research interest in the concept has waned in recent years.

Two other influential papers by Edwards set the stage for years of clinical research by social, behavioral and clinical scientists in the emerging field of addiction treatment and theory. The first study (11) was a randomized trial comparing outpatient treatment with brief advice to stop drinking. Published as a 1977 article in the *Journal of Studies on Alcohol*, both groups showed similar improvements in sobriety, with patients receiving the more intensive intervention doing no better than those receiving advice. The study also showed that two years following treatment discharge, those patients having more severe alcohol dependence did better with the more intensive treatment, thereby stimulating a series of studies on the “matching hypothesis,” which postulated that patients would benefit more from treatments to which they were appropriately matched. In a strange twist on this line of research, Edwards and his statistical colleague Colin Taylor (12, 13) later analyzed additional data collected from the same patients, reporting that their original treatment matching findings may have been erroneous because the effect they observed at two years post-treatment was not present in the first year after treatment. The authors’ honest admission of a possible false conclusion was prescient. Many studies subsequent to theirs also failed to find matching effects (14).

In another example of intellectual integrity, Edwards re-interviewed a series of alcoholic patients who had been studied previously by his mentor, psychiatrist D. L. Davies. The original study (15), published in 1962, reported the counter-intuitive finding that many patients had successfully returned to moderate drinking after being treated for severe alcohol dependence. Edwards’ findings (16, 17), published 23 years after Davies first reported his conclusions, showed that Davies had been substantially misled by his patients and that none of them was likely to have become a moderate drinker.

By the time of Edwards’ retirement in 1994, the Addiction Research Unit had become one of the leading addiction research

centers in the world, with a new designation as the National Addiction Centre signifying both the caliber of the research team Edwards had built and the international reputation it had achieved (18).

Journal Editor and WHO Advisor

Perhaps because both his father and maternal grandfather had been part-time journal editors, Edwards' academic interests gravitated naturally to scientific publishing. In 1978 he was appointed editor of the *British Journal of Addiction*, at a time when the journal's editorial office consisted of three shoe boxes containing several years of accepted but as yet unpublished manuscripts of variable quality and interest value. The *British Journal of Addiction* was established in 1884 and was considered to be the oldest specialized addiction journal in the world. Edwards was proud to be part of a historical legacy that was trying to understand and manage addiction. He spent a decade rebuilding the journal's scientific credentials and academic reputation. His vision for the field crystalized around the journal, using it as an agent of change that would take it from four to 12 issues a year. He expanded the management team, established new editorial offices in the United States and Australia, and built a network of more than 150 assistant editors from 17 countries to help with the refereeing process. By the time Edwards had turned over editorial responsibilities to Robert West in 2004, the journal was rated first out of more than 85 similar addiction science publications in its impact on the scientific field. It had also become a beacon of scientific findings, a sounding board for heated debate, and a leader in the promotion of scientific integrity (19).

Paralleling his progressive immersion in the work of the journal, Edwards developed a lasting relationship with the World Health Organization (WHO), the United Nations agency responsible for global health issues. His 30 years of unpaid consultancy literally put addiction on the agenda of international health promotion and disease prevention, helping to develop model programs for

national responses to alcohol problems, drug epidemics and HIV/AIDS. He contributed to the writing of many seminal WHO publications, including *Alcohol Control Policies in Public Health Perspective* in 1975 (20). The so-called “Purple Book” has served as a model for epidemiological and policy research on the control of alcohol problems worldwide. He was a critical force behind subsequent updates of the scientific literature in *Alcohol Policy and the Public Good* (21) and *Alcohol: No Ordinary Commodity*, (22,23) following the Purple Book template of collaborative authorship, international scope, and attention to the interface between science and policy. There were also collaborative book projects devoted national trends in alcohol control (24) and international research on drug policy (25).

Awards, Honors and Accomplishments

A prolific writer, Edwards was the author or co-author of more than 300 scientific articles, 40 books and numerous reports and editorials. For many years he was one of the most highly cited authors in the field of addiction science. Not only was he instrumental in the establishment of the UK National Addiction Centre, he also was the driving force in the creation of the International Society of Addiction Journal Editors, which now represents more than 35 journals in the field. After his retirement he authored or coauthored several books for the general public (26,27), as well as a historical analysis of Thomas Trotter, a 19th century authority on alcoholism (28).

The recipient of numerous university scholarships, his subsequent academic awards included the Jellinek Memorial Prize for his contributions to international alcohol research (1981), the Evian Health Prize (1986), the Nathan B Eddy Gold Medal for international research on drug misuse, awarded by the College on Problems of Drug Dependence in the US (1986) and the Auguste Forrell Prize for European research on alcohol (1998). In 1987 he was awarded the title of Commander of the British Empire (C.B.E.) for his service to social science and medicine (see Figure 1).



Figure 1: Griffith Edwards in 1987 after receiving the title of Commander of the British Empire (C.B.E.) for service to social science and medicine.

Family, Friends, Patients and Students

A real milestone in Edwards's personal life was his 1981 marriage to Susan Stables. Family life at 32 Crooms Hill in Greenwich, London was organized around their enjoyment of books, music, art, good conversation and fine wines. There were frequent dinner parties with friends, neighbors, and relatives. The guest book in the foyer attested to the warm welcome extended to a constant stream of overnight visitors from all corners of the world. The Edwards' drawing room came as close as could be imagined to a 17th century salon where polite conversation, intellectual discourse, and addiction politics were exchanged among a regular stream of visitors. Griffith Edwards was passionate not only about family, friends and addiction science, he also put his patients in the forefront of his genuine concern for the ups and downs of the human condition. Finally, there were the students from all disciplines and all parts of the world whom he loved to work with. He ran several British Council Courses and was Director of studies for the one year course leading to a Diploma in Addiction Behaviour.

Autobiography of an Addiction Scientist

Now that the readers of this book know what they need to know about Griffith Edwards, it is time to let him speak for himself. In many ways *Seeing Addiction* is the autobiography of an addiction scientist. Addiction research is conducted to understand the causes of addiction, to relieve suffering and to save lives. It is an open field where young professionals from almost any scientific discipline might eventually find themselves attracted to a research career. But what makes a young man or woman decide to take a research direction in the first place? In the first chapter of this book of reflective reminiscences ("Research as a Rich and Rewarding Experience"), Edwards describes addiction science as a new and exciting profession that is likely to interest anyone with an intrinsically curious mind "and for them it would seem great luck

that society licenses such types of employment as a way of earning one's living." Edwards uses the story of his own involvement in addiction research and clinical practice to illustrate how one clinician realized a satisfying research career.

The core symptoms of alcohol dependence have been described in numerous scholarly articles and literary descriptions of people with alcoholism, but it was Griffith Edwards, along with Milton Gross, who proposed the alcohol dependence syndrome concept which has endured in various diagnostic systems such as the eleventh revision of the *International Classification of Diseases* (4, 8). In Chapter 2 ("Seeing Alcohol Dependence") Edwards describes how he developed the syndrome concept and how he mobilized scientific data to make it applicable to the global health needs of the WHO.

Despite the enormous empathy he felt for his patients, he was no stranger to clinical controversies (Chapter 3), and he learned from the lessons that come with differences of opinion. When DL Davies, who was Edwards' mentor and Dean at the Maudsley Institute of Psychiatry, published a two-year follow-up of fifty alcoholics who had been treated at the Maudsley for severe "alcohol addiction" (15), the findings created a sensation. According to Edwards, "This was a bombshell dropped with at least two and a half centuries of previous clinical consensus shattered in a few plainly stated sentences. Seven of the cohort of ninety-three patients who had been admitted for treatment of alcoholism had seemingly returned to untroubled drinking not for just a month or two but for a good stretch of years." This study catalyzed a movement in the alcohol treatment field that became known as the controlled drinking hypothesis, and it motivated the development of new behavioural therapies that attempted to train alcoholics to control their drinking instead of maintaining lifelong abstinence. Many years later Edwards encountered one of those seven patients who revealed that he had lied to the study's interviewer and subsequent tracking revealed that most of the others had never returned to normal drinking, as claimed initially. In 1985 Edwards published the results of his long-term follow-up

(16) of the famous seven patients, not only debunking the controversial findings of his mentor, but also calling into question the validity of the controlled drinking hypothesis (17).

This theme is illustrated in Chapter 4 (“Learning from Patients”), where Edwards explores “the all too seldom talked about questions around the inner world of the professional traveler, i.e., how patients view their addiction and how they believe one can recover from it.” A series of case studies is presented to illustrate the wisdom and the folly of some of his patients. “It is a story of people’s triumphs but also and not infrequently of tragedy.... I believe that I have learnt to what extent people are made by parents, childhood, environment, the view from a sequence of windows. ... I am grateful, I’ve been changed, and am still now changing as a result of what patients have taught me.” One thing they taught him was how to question conventional wisdom about addiction treatment. Another thing he learned was how to translate their stories of addiction into theoretical constructs worthy of clinical research.

In addition to clinical practice with patients who have alcohol and drug dependence, another way of expanding one’s view of the world of addiction is through work in related fields. In Chapter 5 (“The Medico-Legal World”), Edwards explores the benefits he derived from his many years of medico-legal work, which he likens to travel in a foreign land: “To enter this world of the law and lawyers for a doctor is to tread very different terrain than the familiar pastures of the clinician or medical researcher.” Edwards describes what it was like to serve as an expert witness on matters dealing with alcohol and drugs. He came to enjoy the challenges of the cases and the professional lawyers with whom he worked. As described in a series of case studies, his medico-legal consultations included alcohol-related murders, child custody cases, divorce law, commercial disputes between business parties, employment law, a court martial in Hong Kong, and drug- and alcohol-related accidents. He also became involved in the defense of doctors and other professionals who encountered difficulties with professional regulatory bodies because of their substance misuse. “Putting

my experience of criminal and civil law and medico-legal practice into the one basket, I conclude that the experience for me has been one of continuous self-education.”

The publication of a scientific journal is an esoteric enterprise. Few understand its complexity; fewer still can describe how the peer review process contributes to scientific progress, and the personal rewards experienced by those working within it. In Chapter 6 (“*Addiction: A Specialist Scientific Journal as a Living Organism*”) Edwards describes the evolution of the journal *Addiction* from a relatively obscure and parochial British clinical journal to the premier scientific organ for addiction research globally. Edwards believed that it is not only the certification of scientific knowledge that motivates journal editors like him, but also the social benefits of being part of an “invisible college” of scientists, clinicians and administrators who conduct, apply and manage scientific research. “The pleasure lies in the worth of what is achieved – participation in teamwork, the service given to a scientific community and now and then a cautious feeling that the journal is achieving more than it did a few years back.” This chapter captures the excitement of the 25-year tenure of Edwards’ editorship of *Addiction* and it identifies the historical threads in this journal’s long life-course since its founding in 1884.

If the need to see controversy provides motivation to the scientist, the need to see history provides depth of understanding. Chapter 7 explores Edwards’ growing appreciation of history, and how he came to co-author a book about a remarkable 19th century physician named Thomas Trotter (26). From Edwards’ account of his chance discovery of Trotter’s 1804 essay on the causes and consequences of chronic drunkenness, we learn how Trotter’s remarkable career as physician to the Royal Navy, country doctor, anti-slavery advocate, author, poet, playwright and alcoholologist can be an inspiration to those who seek to see the history behind what they do and to learn from it. “This was a doctor who was all those years ago writing with enormous insight about alcohol problems and how to treat them.” To Edwards, Trotter’s story is a metaphor for the “Great Theatre of Life.”

As Edwards matured as a psychiatric epidemiologist, he turned his attention to the connection between policy and science at both the national and global levels. His first exposure to international work was his participation in the formulation of national drug policy in the United Kingdom, but that was soon followed by collaboration with an international group of social scientists in the writing of *Alcohol Control Policies in Public Health Perspective* (20). The main argument of this influential book was that changes in the overall consumption of alcoholic beverages influence the health of the people in almost every society. Because alcohol policy measures can be used to limit consumption, the control of alcohol availability becomes a public health issue. According to Edwards, this thesis “constituted in fact a revolutionary manifesto” that influenced the course of alcohol policy and alcohol policy research for the next 45 years.

The personal and public health benefits of viewing addiction from a social policy perspective are thus captured in the theme of the final chapter of Part I of this book, entitled: “Addiction and the Making of the Science/Policy Connections.” In this chapter he describes his involvement in what came to be called the “Purple Book” and five subsequent collaborative book projects (21–25). According to Edwards, the multi-authored policy reviews that began with *Alcohol Control Policies in Public Health Perspective* continue to point the way for brighter, younger research workers, encouraging them to seek “new policy horizons that need to be scanned.”

As time went by and the Addiction Research Centre’s core scientific activities prospered under his leadership, new opportunities and new treatment concepts were added to the research program. The presence at the Centre of visiting fellows from abroad was a “wonderfully enriching experience” that provided a global dimension to the study of addiction. That global dimension is perfectly captured in the seven travelogues presented in the chapters included in the second part of the book, entitled “Travelling Lightly,” which describe the benefits of seeing addiction through the lens of different people, places and cultures. The journeys to

the USA, Canada, Chile, Kenya, Russia and other countries also reveal how Edwards' career evolved in relation to the emerging ideas and global networks that define the field we now call addiction science. These trips were devoted not only to learning and networking, but also to the spiritual journey of returning to one's country of birth (India) and visiting with the legendary Mother Teresa (Chapter 13). According to the author, "At best, such travel at an early stage in a career should challenge, inspire and perhaps also confuse and invite doubt. That experience is likely to be both emotional and cognitive. There are still inspirations and insights of a quite special kind to be gained from personal contacts, and a view of the world from other windows than one's own." These travelogues show how differences in language and culture are diminished by shared understandings and common experiences in the struggle against addiction.

Seeing Addiction through the Eyes of a Visionary

Addiction is a field of research and policy that is not sufficiently reflective as to both its history and its mode of operation. Perhaps for this reason, it gives little attention to fundamental questions about how we train the next generation of scientists. As he matured as a scientist, as a clinician and as a mentor, Edwards increasingly tried to fill the gap created by the collective amnesia of those who were drawn to this complex and fascinating area of scholarship. In this book he succeeds admirably in describing the essence of addiction and the progress of addiction science through the eyes of a man who could not only see its many facets, but could also describe them with eloquence, wisdom and passion. Of all the benefits that come with reading this book, the one that seems to stand out the most is the author's hope that "There are still inspirations and insights of a quite special kind to be gained from personal contacts, and a view of the world from other windows than one's own."

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PART I

Seeing Addiction: A Kaleidoscope of Perspectives

CHAPTER I

Research as a Rich and Rewarding Experience

Addiction research above all strives to relieve human suffering and to save lives. It is an open field which any professional may consider joining and after one or two rites of passage it is not difficult to become a career practitioner.

What makes a young man or woman choose a research direction? I confess that I myself may constitute an extreme case of how one gets into this position. My father, grandfather, and great-grandfather all lived life as veterinary scientists. I knew I wanted to be a researcher without having any idea of the meaning of the term. It is a profession that is likely to interest anyone with an intrinsically curious mind and for them it would seem great luck that society licenses such activity as a way of earning one's living. However, this is not an occupation which should be entered by someone interested in maximizing lifetime earnings or owning a swank car.

I want in this chapter to give some idea of what the research world feels like to the practitioner of this art and science, a day in the life of kind of thing. I will use the story of my own involvement

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in addiction research to illustrate something of the story of a research career that was rewarding rather than exemplary.

The life and times of the addiction research world

In the summer of 1964 D.L. Davies asked me to lunch in the Maudsley Canteen with a senior medical officer at the Department of Health and previously the brigadier in charge of military psychiatry. They were old friends and likely to settle any difference between them quickly.

And so it was on that occasion. The Brigadier wanted to commission a field survey of community drinking practices. Davies readily agreed to take on this work and volunteered me as the person who would be his agent. The deal was done.

I had no hesitation in grasping this opportunity and was fully aware of my having the good fortune to earn Davies's trust. It was indeed a way to earn trust for I knew nothing about how to design and conduct a house-to-house survey. I think it is safe to say that before that lunch epidemiological research was a foreign land. I went off and sought a medical statistician who was kindness itself but if I'd taken that person's advice the project would have been wrecked before it even started. I then found some more informed colleagues who set me off in the right direction. I read the literature, talked to some more people, designed a comprehensive questionnaire, conducted some piloting, made some adjustments and got on with the job. I had already done a postgraduate course which helped somewhat and had learned about new forms of data tabulation with punchcards. I began to realize that doing research was not an abstract occupation but a truly human endeavour. We interviewed a sample of 950 people. I believe that we met our contract to document variations in drinking patterns across gender, age, and social class. We met also with accounts of drinking problems and were able to offer a new way to classify different types of drinking problems. The Brigadier was all smiles. I saw him later in Washington where he'd taken on a senior health position with the US government. He took me for a ride in his antique Bentley.

In addition and at no extra cost we surveyed in the same district as our main sample all manner of agents and agencies who were likely to have contact with drinking problems. We surveyed for instance samples of doctors, clergymen and representatives of prisons and magistrate courts and conducted a census of problem cases to find out how many were drinkers. We compared the sites against the findings of our door-to-door survey and concluded that perhaps only one person in nine with a drinking problem was in touch with any kind of active help.

The principal personal pleasure at this stage in our research was the progress made in meeting our survey recruitment goals and the privileged access we had to other people's homes. They owed us nothing but for the most part received us kindly and courteously. We offered no fee for assistance in this work but the benefits deriving from this experience still stand out in my memory. An old lady, for instance, told me about a great local street party held nearby to celebrate Queen Victoria's jubilee. Her account was so vivid that I could conjure the bands playing. And another evening, on a visit to a high-rise block, the owner showed me the site of a luxury cocktail bar. Afterwards, he insisted that we sit ceremoniously at the bar together while he poured me a Tom Collins. Someone pointed to nearby waste ground and said: "Yes, my mum heard it go off, 1944, that V2 killed 30 people".

Extraordinary scenes portrayed for me and always as a side stem of the research, the kind of anecdotal material young researchers recall when they are just learning their trade.

When the Department of Health money was about to run out the Secretary of the Institute of Psychiatry rightly reminded me that further funding for my team was uncertain. She estimated the chances of a follow-up study to be "probably impossible." She said that she expected to see us all on the street before long because we were a young group with little track record in conducting alcohol research and therefore were unlikely to be of interest to grant givers.

Good fortune then led me to a private foundation that gave me wonderfully generous advice on how to prepare a research funding application. The people showed such kind and sensitive handling of

a young and inexperienced group of researchers. Before long we were not out on the pavement but had six staff positions rather than the previous three and a chance to explore some new horizons.

Certain things in particular stand out as my main learning experiences of that time. First, I was feeling the sense of how to write a research grant application – never submit a grant until it is well-reasoned, and has a succinct argument to justify the project. Second, identifying a good question is the necessity of all research and the reason why some people have a lifetime passion for the job. Third, someone who is of collegial disposition and pleasant to work with, hardworking, and possessed of integrity is probably more likely to succeed in research. With that in mind I was so fortunate as to find a graduate psychologist to take one of the post-doctoral positions. Jim Orford is among the brightest of researchers I have ever had the privilege of working with. He subsequently received the Jellinek Award, the premier international prize for alcohol research. I think the awareness began to dawn by that time that the right question is likely to emerge if one can identify helpful input at the planning stage. I would hope to see it in virtual reality before encouraging someone to go into the field. Research design, baseline measurements, outcome definitions and statistics, these are all the things with which Jim was likely to start a study plan. And yes, hold onto imagination, intellectual daring, and never let research become dross (rubbish).

So where do the research ideas come from? I believe that in clinical research they often come from something a patient says, but I must have ears with which to listen. Some years before I had had a former patient come up to outpatients specially to tell me that I had on an earlier consultation with him given very bad advice. After initial assessment I told this patient that if he wanted to become sober he would have to accept a lengthy inpatient stay in the Maudsley as the only feasible way of obtaining that goal. The patient said that he did not heed that help, and would not accept it. He said that I looked gloomy and showed him the door.

Our later controlled trial with inpatient versus outpatient treatment (1) was inspired by my meeting with this man. We found

that at 12 month follow up there was no significant difference between the two groups. The then consensus view that residential care was the absolutely necessary treatment for any significant drinking problem was struck down.

I was then convinced that another sign of a creative research team will be the ability to reflect on its own accomplished piece of work and proceed to enlarge and reshape the question. This is the ability to follow through with an idea and line of work, to take things further and stay with it. What we stayed with was a two groups comparison study with one group again receiving an intervention that was conventionally favoured at that time. The intervention group comprised residential treatment of a reasonably intense kind, and the other was given one session of brief advice, which involved simply an intense recommendation for achieving and maintaining sobriety. The result of a follow-up interview after one year was that treatment and advice produced very similar results (2). That finding forced us to make a fundamental reappraisal of what was meant by "treatment." In this new perspective, treatment was seen not as a hard intervention, something done to patients, but as an enabling of people to work their own recovery. Some advice which fits with the patient's idea of appropriate support, some good cheer, some laughter, some picking up of people again when they fall down, that's the essence of treatment and nothing much more grand.

In 1967, the Department of Health asked for my support to develop a research centre to deal with the nation's heroin problem. We won this funding which for the first time looked like very long term. It included eight or nine new positions. The idea was to draft these new appointments from the previous alcohol research group and create one entity that was called the Addiction Research Unit. Around this time I met a young South African psychiatrist in the lunch queue at the Maudsley canteen (the site of so many important happenings). His name was Michael Russell. Mike went on to revolutionise British nicotine and tobacco research and to become an esteemed international figure in that world (3). Somehow I managed to get hold of a packet of money

to allow him to work in the new Unit. He recruited his own research team and had his own funding in due time, and operated entirely autonomously. He personally recruited a research team that operated with brilliance and four or five obtained university chairs. Jim Orford headed an alcohol research section and we recruited a very able psychologist from Australia, David Hawks, to run the drugs side. And our basement lodgings were traded for a comfortable two-story building.

Somewhere along this road, it is difficult to identify the precise moment, I became aware that this research team identified its own strong identity, its own energy. The whole was greater than the sum of its parts and everyone worked as a team. People would often move on and find employment elsewhere but somehow we were time and again renewed and I became grateful that the collaborative effort made by my colleagues was made into a golden age. I therefore will be forgiven if I do not mention every person who contributed to this creativity and made the place so rewarding to work in. But there are a few key people whose contributions deserve special mention. Ray Hodgson was a psychologist who with Tim Stockwell as his junior worked with great skill on the development of the dependence syndrome idea and its measurement. He showed an astonishing ability to develop this line of thinking. Ray eventually left for a chair in Cardiff and Tim after leading a research group in Perth, Western Australia, ran a remarkably productive research group in Victoria, Canada. Some people's work gets a little stale as the years go by but Tim's seems to get ever more productive. A group involving Jerry Stimson, Edna Oppenheimer, Maggie Sheehan, and Clive Tobutt worked at the longitudinal study of drug addicts and showed that over a 20-year period their mortality was likely to exceed normal death rates by 11-fold. Ilana Glass not only established her own research niche but showed gifted ability in conducting scientific reviews. Hamid Ghodse carried out seminal drug research particularly on addicts attending London casualty departments. When he left us he established at St George's Hospital the Addiction Behaviour Department and the first British teaching hospital chair. For many years he was the British representative to the UN International Narcotics

Control Board, with the accolade of receiving a lifetime achievement award conferred by the Royal College of Physicians. Colin Taylor did service as a statistician as well as an alcohol researcher and later became a senior scientist at the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, Portugal. Colin Drummond joined the team as a young addiction psychiatrist in 1987. He left for a time for a chair at St. George's and then came back to hold his own chair in addiction psychiatry at the Institute. Figure 1.1 shows a picture of the researchers affiliated with the Addiction Research Unit in the early 1990s.

The research unit and the add-on bits

As time went by and the unit grew, new opportunities were added to the research program. I am not sure that these add-on activities



Figure 1.1: Research team at the Addiction Research Unit in the early 1990's. (From left to right) Gail Sutherland, Stephen Sutton, Peter Hajek, Ronaldo Laranjera, Martin Jarvis, Michael Russell, Griffith Edwards, Ilana Crome (née Glass), Colin Drummond, Mary-Alison Durand, Michael Belcher, unidentified team member, Steven Glautier, John Stapleton.

ever achieved their own research identity but it all vastly added to the buzz of the place, its life and times. Here I will identify quite briefly some of these very diverse happenings.

Helping Hands

We were involved in setting up the first hostel for recovering alcoholics run by what was then called the Helping Hands organization, in Camberwell. I or one of my registrars would go around in the evening to have supper with the residents and we promoted the idea of a therapeutic community structure.

A therapeutic community for homeless drinkers

Giles House in Camberwell was set up to serve underprivileged and stigmatized people. The first director of this project was Timothy Cook.

Phoenix House

This was a therapeutic community for drug addicts which we set up in a church hall and later was developed into a national organization.

The Community Drug Project

This was a Camberwell-based organization which was intended to work as liaison with Phoenix House.

The Experimental Consortium in Community Endeavour

This project aimed to assist voluntary social work organizations to work together on such issues as funding, staff training, and purchase of rations and equipment.

Working with governments

Several of us were asked to advise governments. I over time gave advice to the Foreign Office, the Cabinet Office, the Department of Health, the Home Office, and the Department of Transport. I learned something of the skills involved in courteous and patient advice giving without expecting one's advice always to be taken. Besides the British government department I at times assisted other governments and was a consultant for the White House.

Research fellows

The presence of visiting fellows from abroad at our centre was a wonderfully enriching experience for our staff. Fellows from America, Canada, Germany, Japan, and Thailand were among their number.

Teaching experience

After some years we decided to establish a diploma in the addictions and this later was converted into a master's course. Teaching responsibilities were widely shared by unit members and it was enormously rewarding. We established an international friendship network. We never neglected our research responsibilities. The research unit over time became much more lively, productive and international in its scope.

In 1993 when I retired from my position at the Institute of Psychiatry I was delighted to have my friend and colleague John Strang take over my position. I did not doubt that he would in several ways do better than I had ever done and this expectation was not disappointed. Furthermore, I kept a small office and would occasionally have the pleasure of John calling in. Such visits brought sunlight to any day from his charm, his kindness, his wit, and sagacity. I do advise transitions.

Despite all of these enormous developments, did I make mistakes and miss opportunities? Yes, I did.

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CHAPTER 2

Seeing Alcohol Dependence

This chapter uses the word “seeing” in its title, and with stronger intent than mere metaphor. Withdrawal symptoms are of course very important. They contribute to the genesis of alcohol dependence and are one of the diagnostic features that define this syndrome. But that syndrome has more to it than any one criterion. It is a whole which is greater than its parts. This chapter will outline the idea of such a syndrome first, then describe how researchers then sought to confirm that the idea had reality, and finally examine some recent challenges to that thinking that have emerged. I’ll be talking of people as well as ideas and believe that a summer’s day in a Hampshire landscape is a legitimate part of the story.

Listening to lots of patients

From April 1959 to June 1960 I worked as a trainee in D.L. Davies’s firm at the Maudsley. On our arrival at the hospital we were given mimeographed notes on how to take a psychiatric history from a patient. These few sheets were a foundation for everything clinical that would follow. They provided a lifetime framework for

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interviewing anyone who later we would meet as a patient. It would henceforth be a matter of “hello Mr/Mrs/Miss Smith”, and then move on to intense hours of formulaic questioning. The intention was to ensure that all major aspects of the individual’s life course were explored in minute detail with time along the way for introspection, self-doubt, murmurings, and the humanity of the occasion. Here are some of the headings which this rubric included: family of origin; quality of relationships within that family; early child development; childhood health and any neurotic symptoms experienced in childhood; schooling, social adjustment at school, truanting and any disciplinary problems, grades attained; higher education attainments; a chronological job history; sexual development; marriage and children; lifetime physical and mental health history; and personality characteristics. And then and only then a history of the present complaint. All these years later that formula is still prominent in my mind. Taking a “Maudsley history” is an art form and at best an invitation to hear the music of the spheres¹. Take a hundred of such histories and one’s understanding of one’s own life will inevitably begin to change.

There was however one gap in the Maudsley’s instruction sheets of which I before long became aware. In teaching us how to count angels on the head of a psychiatrist’s pin, they provided no hint at all as to what we should ask our patients about their drinking. Davies himself was by nature both astute and exacting, but he had no formula here to put on offer.

Over the course of fifteen months as Davies’s apprentice I probably took a Maudsley history from about 75 patients who were in difficulties because of their drinking, having in 1962 achieved a postgraduate qualification in psychiatry, which allowed me to initiate some work on drinking. The work focused on compiling a list of alcohol-related symptoms frequently reported by alcoholics in their clinical interviews. A tally of the patient’s dependence scores correlated closely with frequency of previous petty

¹ A philosophical concept that regards proportions in the movements of celestial bodies – the Sun, Moon, and planets – as a form of music.

offending. These scores predicted, for instance, the most recent arrest being for drunkenness, and related also to the kinds of previous drunkenness arrests. The measure thus seemed to be in some ways validated.

In 1973 I was invited to chair a World Health Organization (WHO) Committee which was charged with making an internationally-based proposal on how the problem of drinking could be defined in the light of contemporary scientific knowledge. The key partners in this enterprise were Robin Room (a social scientist), Milton Gross (a biological psychiatrist), Mark Keller (an alcohol scholar who worked at the Yale and Rutgers alcohol research centers), and Joy Moser (the highly experienced WHO staff person who headed the agency's work on alcohol). We had the facility also to develop position papers more widely. After a few years of deliberation we submitted a draft report to an especially convened international WHO conference held in Geneva in July–August 1975. There we had the opportunity to receive comments from a broad range of alcohol scholars from around the world. We were cheered when Kjetil Bruun, a Finnish social scientist who was suspicious of anything in which a medical doctor had had a hand, told us that he was happy with our formulation. But Georges Pequignot, a revered French epidemiologist, issued a diatribe against what he saw as “typically mentalistic Anglo-Saxon habits”.

Milton Gross undoubtedly contributed to the development of my personal understanding of the problem with which we had been charged. He was a Harvard graduate with clinical and laboratory appointments at a New York state hospital with a very busy private psychoanalytic practice. He was a big man with an enthusiastic manner who had a highly informed understanding of art. His collection of West African carvings probably at that time exceeded any assembled in private hands. Whatever the demands of our WHO responsibilities, we would be off to visit art galleries together whenever the chance arose, and I would learn from his taste and sensitivity.

The profound importance of Robin Room's thinking for the group's deliberations also deserves to be acknowledged. He

insisted that the alcohol dependence syndrome would not be allowed to monopolize our mapping of the problem with drink. He pointed out that survey research demonstrated the existence of a vast and amorphous array of drink-related problems occurring among people who were not dependent. His review (1), written as a position paper for our group and entitled "The two worlds of alcohol problems," remains a classic of the literature. Milt and Robin's thinking were in some ways the two pillars around which our report would come to be built. And Robin's energy and enthusiasm, encyclopedic knowledge of the field, together with his courtesy were qualities from which we all derived benefit. This was a group which not only generated original ideas, it also over time generated much friendship.

But when I saw the draft report of the 1975 meeting prepared by the secretaries in Geneva, I felt that the proceedings had somewhat lost touch with the alcohol dependence syndrome idea and had as a consequence blunted the sharp edge of its clinical reality. I decided therefore and ahead of the publication of the WHO report (2) to write up my own best attempt to profile the alcohol dependence syndrome. In so doing I had the sense of all those patients I had interviewed over the preceding years telling me what to say, and with all the recent impact of Milt's and Robin's scientific erudition further input. The resulting paper was published in the *British Medical Journal* (BMJ) in 1976, under the title "Alcohol dependence: Provisional description of a clinical syndrome" (3). It was no mock modesty to describe this as a "provisional" description. Although we believed that we were describing a clinical reality, we knew that we were getting ahead of scientific research which, if feasible, would have to come later. The BMJ paper, however, was seen as helping set up a research agenda.

We started to define what we meant by "syndrome" as a phenomenon characterized by the likely interaction of a variety of signs and symptoms. A syndrome is an empirical and agnostic concept in that it does not speak to causation or the nature of the underlying pathology. It is likely to exist in various degrees of

intensity rather than being monolithic, its expression coloured by external or internal influences of various kinds.

The paper continued with a description of the seven elements of alcohol dependence syndrome and this is the original listing:

1. Narrowing of drinking repertoire in terms of daily pattern and context of drinking
2. Increased salience of drink-seeking, so that other interests or responsibilities may take second place
3. Increased tolerance to alcohol
4. Repeated withdrawal symptoms, usually observed on waking when blood alcohol levels are at their lowest
5. Relief of withdrawal symptoms after drinking, particularly first thing upon waking
6. Awareness of a compulsion to drink and impairment of control was emphasized as opposed to the complete “loss of control” described in the disease model (4)
7. Rapid reinstatement after abstinence, so that only a day or two after returning to drinking all the above signs might return in full force.

Both biological and psychological experiences were caught up in this formulation. This statement in part derives from a close reading of the research literature but it also borrows directly from the experiences of what all those patients had over the years been telling us. The syndrome concept sought to make their voices heard. The clinical description of these signs and symptoms should be seen as in some ways constituting a missing alcohol dependence addendum for the Maudsley psychiatric history instruction sheets of long ago.

And in passing, this sought to touch base with the return to normal drinking question (See Chapter 3 – Seeing Controversy). We argued that if one could accurately measure the severity or degree of this dimensional syndrome’s expression, the question probably answered itself: drinkers scoring high on dependence were, we predicted, unlikely to be able safely to venture into controlled, non-risky, normal drinking, whereas those who had never sustained more than a moderate degree of dependence might do so.

But the invitation was to think about dependence quantitatively rather than as an all or none phenomenon.

Besides seeking to delineate the benefits of a dimensional reality, this paper proposed a second very important alcohol-related dimension, this time as witnessed by Robin Room's input. This was the dimension which we at this time characterized as "drink-related disability." Here is what we said under this heading:

"A person may, for example, develop cirrhosis, lose his job, crash his car, or break up his marriage through his drinking without suffering from the dependence syndrome. The syndrome should therefore not monopolise medical or social concern. Nevertheless, physical, mental, and social disabilities often accumulate for the person who is dependent and are more likely to be incurred the greater his dependence" (3, pp. 1060–61).

Our paper thus proposed a two-dimensional mapping of the field at this time.

The paper signed off with a statement of implications for society of the fact that its favourite recreational drug had the capacity to set up in some people a devastatingly compulsive state. We ended thus:

"Without withdrawing sympathy from the nondependent drinker who is experiencing harm, society should be asked to realise that the person who has become dependent on alcohol is certainly ill and the possibility of contracting this illness awaits anyone who drinks very heavily" (2, p. 1061).

The syndrome concept thus challenged the self-comforting and up to that time pervasive assumption that only the predetermined minority would ever become victims of "alcoholism".

Responses to the 1976 formulation

This formulation derives from a WHO exercise and subsequent to the report's publication, I was asked to write a position paper

which was adopted by WHO's machinery that was at the time preparing the tenth revision of WHO's international classification of diseases (5). At around the same time I was invited to act as an advisor for a committee of the American Psychiatric Association (APA) which was preparing a revision (6) of its influential Diagnostic and Statistical Manual. Thus the WHO and the APA adopted the two-dimensional formulation rather quickly and the syndrome concept was given space in the two major international diagnostic manuals. Inevitably, the requirements of having a binary classification of each disorder meant that the ideas were simplified and the dimensionality of the dependence concept was reduced to a "yes or no" decision rule.

The idea of the dependence syndrome did however attract some criticism. The then director of the American National Council on Alcoholism (NCA), Dr. Frank Seixas, wrote a near defamatory letter to the editors of BMJ in which he stated that the Edwards and Gross concept constituted no more than a plagiarism of the NCA's previously published diagnostic criteria. More constructively, Stan Shaw, a gifted young social scientist who was at the time working at the Addiction Research Unit and in his spare time played in a band, published an attack on the dependence concept (7) which he saw as an attempt to establish psychiatric hegemony in his field. Some of the array of published responses deserved respect or attention and helped to carry our ideas forward, while others were not very well thought out or even bizarre.

Something very sad happened not long after the two dimensional idea had achieved recognition. On July 29, 1976 Milt Gross died of a brain hemorrhage. He had for some years been suffering from hypertension. Although he had hinted to me that he feared for his survival, he never cut back until the last on his demanding professional schedule. He left a devoted wife, Lucy, two daughters and a young son with whom he liked to go fishing. I lost a greatly valued friend and the field lost a gifted mind.

The international response to the dependence syndrome concept is something which I watched with the closest interest in terms of the research conducted in various countries to test the

idea. Notable among American contributions was a group of alcohol researchers at the University of Connecticut which included Roger Meyer (8) and Thomas Babor (9). Bruce Rounsaville at Yale University (10) and Jonathan Chick working in Edinburgh (11) were among the other contributors at that time.

Particularly influential on the development of ideas at my own research base, the Addiction Research Unit at the Institute of Psychiatry, was the appointment in 1977 of Ray Hodgson to our research staff. Already established with a reputation for research on the treatment of anxiety disorders, that kind of experience provided a very relevant basis for investigating the alcohol dependence syndrome. And I was immediately impressed by the range of investigative techniques that he was equally at home with, ranging from self-report questionnaires to observations of the sip-rate of drinkers through a one-way screen. Ray worked with a number of able younger researchers including Howard Rankin, Duncan Rastrick and Tim Stockwell. The subsequent careers of these talented people were remarkably diverse. Ray moved to University of Wales and later served as President of the Society for the Study of Addiction. Howard moved to private practice in the USA. Duncan became director of the Leeds Addiction Unit. Tim went on to achieve great personal success as a researcher and a director of important research centres in Australia and Canada. It was great good fortune to have these colleagues join in the unit's work at that particular moment, and the result was an immensely productive series of publications centering on the alcohol dependence idea (12–13).

In 1986, at the 10-year point following publication of Edwards and Gross (3), I produced a paper entitled “The alcohol dependence syndrome: a concept as stimulus to enquiry” (14). That paper summarized not only our own relevant contributions up to that date, but also the remarkable contributions of other groups such as those mentioned above. Much of that work centred on the measurement of the syndrome as a dimensional construct that varied according to its severity (15). Tim Stockwell and colleagues (16) translated the syndrome formulation into a reliable questionnaire format. Much of the research reviewed at that time dealt with

issues around “syndrome validation.” That term embraced variety of investigations aimed at demonstrating the syndrome’s coherence and dimensionality (17, 18) as opposed to it being only the arbitrary invention of the observer’s eye.

I ended that 10-year review with the conclusion that the syndrome concept had catalyzed a range of productive contributions from many different centres, such that it was beginning to look like a ‘useful idea’. Nevertheless, it was still vast open landscape for further research and I emphasized the continued need for interdisciplinary enquiry rather than perseverance with the unproductive rhetoric of the ‘disease’ concept of alcoholism.

Although most of the Addiction Research Unit’s work at that time focused on dependence, important research was also being conducted with the problems side of the bi-dimensional model. Colin Drummond and a colleague (19) explored the structure of that dimension and designed the Alcohol Problems Questionnaire.

It is in retrospect difficult not to see this period as a critical phase in the Addiction Research Unit’s life and evolution. The whole was so much greater than the parts, with the atmosphere truly collegiate. The dependence research was only one section of the larger research enterprise of this group. And although the research space was a prefabricated hut in Camberwell, we came to the view that we were truly living in the world.

Henry Maudsley, the eminent Victorian founder of the Maudsley Hospital, provided me with the apt closing words for my 1986 paper.

“I conclude that man as a whole is a grander and more mysterious complex than any single method of minute inquiry—be it chemical, physical, pathological, microscopical, or psychophysical—will ever unfold . . . There is work enough for as many methods of study of mind as are rationally based . . . but know that in the end they must bring, and knowing, strive to bring their results into harmony” (20).

The patient as starting point and end point at the end and the beginning, that seemed to be Maudsley’s message at any one point.

Broadening the dependence syndrome formulation, alcohol and other drugs

In August 1980 the WHO convened a meeting in Washington DC to consider “the whole field of drug and alcohol related problems” (21, p. 225). That rather expansive phrase was a way of saying that WHO had decided it would be useful now to explore the possibility of generalizing the idea of “dependence syndrome” from alcohol to other drugs. I was asked to be chairman of this group and flew out to Washington with Ray Hodgson who was to be entrusted with the job of rapporteur for this meeting.

Anyone who has participated in a particular field of endeavor over a good few years is likely to fall victim to the whimsy that they were living in a golden age, and I have already succumbed to that belief based on a meeting of the best minds in addiction science that took place in Washington in 1980. My reasons for this view were several. Firstly, the meeting was part of the WHO tradition at its best: we knew that we were in this committee room to serve the world rather than being there for our own aggrandizement, to listen as well as to talk, and to see vividly landscapes other than our own. Second, there was the sheer comradery and good will of the occasion. No one was in business to cut other people up; there was the extraordinary power of the scientific input as a consequence of WHO’s prestige and pulling power. Committee members whose input deserves particular mention included Jerome Jaffe (USA), Harold Kalant (Canada), Sheila Blume (USA), V. Poshyashinda (Thailand), Bob Schuster (USA) and Mustafa Soueif (Egypt).

The report (21) that emanated from this meeting concluded that alcohol and drugs are susceptible to the same kind of analysis but with due respect for the fact that each drug might produce a different combination of dependence syndrome elements and different types of problems. The picture offered was of generalizable two-dimensional mapping with distinctive substance, or substance class, variations. The importance of the biological process which the committee described in terms of neuro-adaptation was recognized, but equally the syndrome of dependence had its

psychological and social elements. The report very accurately gave an account of what happened at that meeting but the “goldness” of such an occasion can never be adequately captured in a WHO memorandum, however skilled the rapporteur.

At 30 years and some root and branch questioning of the two-dimensional concept

In 2007, TK Li, a senior and much respected figure in the American biological research world on alcohol and Director at that time of the important US governmental agency, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), published a lecture he delivered in the form of a paper called “The alcohol dependence syndrome 30 years later” (22). The paper gave generous attention to 1976 syndrome concept paper (2), at the same time lightly emphasizing that it was, as stated by the original authors, only “provisional”. It went on to suggest that on the basis of more recent research, the dependence syndrome formulation now needed to be revised. Their main claim was that dependence and problems were not two separate dimensions but one. In terms of Thomas Trotter’s essay on drunkenness (23, see Chapter 7) the medical, psychiatric and social complications of drinking and the “evil genius of the habit” were now to be put all into the same hopper. Some of us might be inclined to reject this formulation out of hand as contrary to clinical reality. TK Li’s suggestion was underpinned by the substantial American general population survey based on drinking, drink problems, and dependence symptoms, along with advanced statistical treatment of the resulting data. The skills and experience of the researchers were outstanding.

The technical problems with the survey data are however considerable. It is commonly acknowledged that interviewees who are the target of science surveys tend to minimize or underestimate the quantity they actually drink with heavier drinkers being more intensely in denial. The validity of responses to dependence questions in such surveys is also problematic especially in relation

to questions about tolerance. The paper by Li *et al.* seemed to be a harbinger of the position to be taken by the American Psychiatric Association working party that had been preparing a fifth edition of the diagnostic and statistical manual (DSM-5).

The debate whether alcohol dependence is or is not a separate dimension to alcohol related problems is not yet resolved. My aim is to suggest that the surveyors failed to effectively connect with the human realities. I would not want to make a fetish of what my patients tell me and am only too aware of the long history of doctors letting their experience with a group of patients at a clinic define the total spectrum of reality. What my next patient is likely without prompting to tell me is that they drank heavily for many years and encountered many alcohol problems along the way. But then at some point something novel kicked in – first a man takes a drink and then the drink takes the man, and that is where dependence supervenes.

Postscript: Milton Gross remembered

I am so fortunate as to go on knowing Milt's widow, Lucy, and her now very grown up family. They are all most welcome visitors when travel occasionally bring them to our home in London.

Milton's son, Joe, broke with family tradition and become master of a cargo ship before turning to a career in ship's brokerage. One day he emailed me with a request that I should write something for his son, James, Milt's grandson, who was then 10 years old. James never knew his grandfather but had been asking recently about him, and seemed to have the need to establish Milt's reality in his young life. His father was asking me to write to this lad and tell him something of my memories of our friend.

I gladly consented – but what then to write about Milt? His habit of bear hugging which was capable of embracing the whole of Geneva airport in its grip? What new horizons he opened for me when in New York we walked together around the Museum of Modern Art? So many memories. I remember this summer day of London heat when Milt, who had been staying with me in

Greenwich, asked me to drive him the 70 or so miles west along the M4 motorway and then take country roads across the mystical landscape near where I spent my country childhood.

After we stopped and were walking across a field Milt suddenly bent down to pick up a strand of flint stones. He was fascinated by the shapes, colouring, and luminosity of this terrain. He flew back to New York with a fine collection of stony pickings as trove of that day's adventure.

I told that story to James to involve him in the realities of a day which I had shared with Milt. Joe reported that James had been delighted by what I had tried to tell him about Milt and had been reading and rereading that letter. The funny thing was, James was himself a picker up of stones and had come back home with his jeans bulging with the treasure.

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CHAPTER 3

Seeing Controversy: D.L. Davies and the Return to Normal Drinking Question

The organizational context

When in 1959 I joined the junior staff of the Maudsley my first attachment was to the unit that was led by D. L. Davies (or DLD as he was usually known), the then Dean of the Institute of Psychiatry. Although Aubrey Lewis was at the time the Institute's influential and mythic Professor of Psychiatry, he had appointed Davies to the Deanship on the strength of his wartime command of a military hospital in India. Lewis would tell people what to do, and he told Davies to do administration – rather than inviting him to take up a research career. The hospital's junior medical staff decided one year to put on a Christmas play which had Davies as a poodle led onto the stage by Aubrey. This incident led forthwith to closure of this particular dramatic performance and a ban on all further Christmas shows by the hospital's junior staff.

On joining DLD's unit I enjoyed the experience of a twice weekly ward round (or clinical conference) chaired by Davies. There would usually be a couple of registrars and a senior registrar

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present together with Edgar Myers, DLD's Psychiatric Social Worker who had fought on the Republican side in the Spanish Civil War. Nurses were then seen as lesser people, mere lackeys, who were not invited to participate in these occasions. The meetings were always demanding with DLD's astuteness much in evidence. He would often inquire as to what regiment an ex-serviceman had served in, and anyone who had been a sergeant in a good regiment of line was predicted to have a favourable prognosis. The patients DLD looked after represented a cross section of general psychiatry but he had developed a special interest in alcoholism, with perhaps half a dozen patients with that diagnosis on the ward at any one time. They were all prescribed Antabuse, and it was the availability of that drug which had sparked DLD's interest in the subject. He was not a believer in any form of psychotherapy and abominated Freud. Group therapy was excluded from the care plan because of Davies's fear that if patients should get together they would foment mischief.

At the personal level anyone meeting DLD at this stage of his career would probably have described him as dry, and a little remote. If one met him in the Maudsley corridor, he was more likely to avert his gaze than give a friendly nod or smile. Under DLD's tutelage I was certainly learning psychiatry from an experienced, down-to-earth practitioner who preferred facts to theory. I did not expect him to become a life influence.

Against expectation I realized after a few months that the seemingly unsmiling Dean had a capacity to nurture, encourage, and generally care for his junior staff. And he much supported my nascent interest in drinking problems, helped me set up some research on this topic, put up generous travel money so that I could enjoy the inestimable learning experience of a study tour in America (See Chapter 10), and he gave me time and shelter when I was working at my MD. That I was given the opportunity to develop a research career was largely due to DLD. Aubrey Lewis had by contrast shown no interest in alcohol studies and gave me little encouragement.

Origins of a controversy

In 1956 Davies had with Michael Shepherd and Edgar Myers published a two-year follow-up of fifty alcoholics who had been treated at the Maudsley (1). It was published in the *Quarterly Journal of Studies on Alcohol* (QJSA), a leading American journal. By the standard of today's professional expectations Davies's paper was lacking in any statistical treatment for the outcome data, and other criticisms could also be made of this contribution. But judged within the standards of its own time it was a significant contribution to the literature. The data on which that paper was based derived from a routine follow-up inquiry which was sent every 12 months to all discharged patients by the Professional Unit's administrative office. The woman who ran that system, Sarah Frisby, would write personal letters of great charm to these patients and get Davies to add his signature. He acquired a reputation for exquisite human sympathy.

With the 1956 paper published, Edgar Myers one day told Davies that something quite unexpected was happening. The continuing Maudsley postal follow-up was seemingly showing that some patients had returned to normal drinking. At that time the absolute clinical consensus was that once someone had contracted alcoholism, they would always be an alcoholic. They had a straight choice between continued self-destructive drinking and total, unremitting, lifetime abstinence. That edict was imbued as scientific law viewed with an almost religious authority.

Davies immediately saw the clinical importance of what Myers was telling him. Rather than dismissing the report as incredible or blasphemous, he arranged for a Psychiatric Social Worker (PSW) to visit the home of each alleged normal drinker to interview the patient and, separately, their partner. Seven cases, all male, appeared to have their stories confirmed.

Davies in his spare but very readable style of writing soon had a report drafted, this time with himself as sole author. The paper was initially submitted to the *Lancet*, which rejected it on the

grounds that it was not of sufficient general interest. Davies next tried the QJSA and was successful. Mark Keller, the editor of this journal, subsequently described his immense excitement at seeing this report come across his desk – he claimed (2) that he'd been expecting such news for some years and now he had it not from some fly-by-night opportunist but from the Dean of the revered Maudsley Hospital.

“Normal drinking in recovered alcohol addicts” was published in 1962 (3) together with comments from a number of invited clinical experts. These comments must have considerably added to the impact of the paper's publication. Keller was a gifted publicist who could spot a winner. The rather retreatist Dean thus achieved overnight international star status. Numerous lecture invitations followed along with considerable indications of outrage. Davies was warned that if he visited America, Alcoholics Anonymous would throw empty bottles at him on the landing strip. I later nominated Davies for the Jellineck Memorial Award, the premier international scientific prize in the alcohol research field, and was delighted in 1978 to attend the dinner at which Davies received his statue bust of Jellineck, the founding father of post-World War II modern alcohol studies. Davies became a figure held in particular affection and respect by the younger generation of alcohol researchers and he took to wearing colourful ties and growing his hair rather long. He seemed to be enjoying a sort of familiarity with younger people at the Maudsley that the position of Dean had previously not allowed him. I personally at that time had no doubt as to the revolutionary importance of Davies 1962 paper, nor did I question the genuineness of his findings.

Let's now turn in some detail to what Davies had to tell. He started by citing an array of experts who supported the then orthodox view that the treatment goal for alcoholism had to be maintained: abstinence. Attention was then paid to the definition of the term “alcohol addict” with the World Health Organization (WHO) report (4) of 1951 taken as authority. According to Davies' reading of the WHO report, the “addictive phase of

alcoholism” was said to be characterized by “loss of control” as its hallmark, with, in addition, “an overpowering need to continue drinking and to obtain drink by all means, as well as a dependence on drink” (3, p. 94). The meaning given to the term “dependence” was unstated. Davies by inference identified seven patients meeting the definition of alcohol addiction, and he reminded his readers that all seven of them had “come under notice for excessive drinking ... so much that they had entered the Maudsley Hospital for treatment” (3, p. 94). Davies was thus assuring his readers that his patients were, by any reckoning, “real alcoholics”, rather than some freak sample with lesser kinds of problem.

The paper then went on to detail the content of the treatment program the Maudsley at that time offered to its patients: “The treatment was directed against addiction as defined by the WHO Committee and the measures used in each of these men included disulfiram (Antabuse), discussion with the patient on an individual basis, and social work with relatives and others” (3, pp. 94–95).

Information was next given on the follow-up procedures which had been employed. In addition to the routine postal enquiries sent out by Mrs. Frisby, personal inquiries of the following kind had been made:

“A psychiatric social worker made a personal visit to their home and in some cases to their place of work. Among other matters she made specific inquiry (from relatives as well as from the patient) about this drinking history since discharge. That information was collated with the other follow-up information gathered earlier in routine inquiries” (3, p. 95).

And then to the key results:

“Each of the seven patients ... after a brief period of complete abstinence often a year after discharge resumed drinking of a normal kind. This means that their use of alcohol had never gone beyond the levels regarded permissible in the cultural groups from which they are drawn ... none had been drunk even once in the seven to eleven years since discharge” (3, p. 95).

This was a bombshell dropped with at least two and a half centuries of previous clinical consensus shattered in a few plainly stated sentences. Seven of the cohort of ninety-three patients who had been admitted for treatment of alcoholism at the Maudsley prior to 1955 had seemingly returned to untroubled drinking not for just a month or two but for a good stretch of years. And it was the deeply respected and characteristically cautious Dean who was author of this report rather than anyone likely to be careless of his reputation.

The eighteen comments on Davies's paper that were published in the QJSA were for the most part questioning rather than accepting or supportive of Davies's conclusions. Davies's reply (6) to this largely negative response from a group of clinicians who were not short of clinical experience was courteous, reasonable and restrained. The tenor of the debate is reflected in a paper I published in 1985 (5). Davies, although in no way retreating from his stated conclusions, was thus conservative in the interpretation of their clinical significance. He was far from advocating return to normal drinking as a new standard treatment goal.

Behavioral psychology tackles controlled drinking

The revelation that Davies's 1962 paper had constituted was renewed about twenty years later by a comprehensive review (7) of the outpouring of public discourse that had followed Davies's 1962 paper. Nick Heather and Ian Robertson, in a volume published in 1981 entitled "Controlled Drinking", attempted to identify some conclusions from the mass of research on controlled drinking that was by then to hand. The authors were two clinical psychologists and that in itself speaks to a change in a field which had previously been dominated by the psychiatric perspective.

What Heather and Robertson's review described was the open-mindedness and sense of adventure attaching to the forward march of alcohol research resulting from the publication of Davies's report. It captured the sense of new dawn and old temples torn down.

The central conclusion which Heather and Robinson felt able to offer at that time was that “return to normal drinking” had by that date been shown to be not just a rare outcome but a likely achievement for 5–15% of all treated alcoholic patients—two American researchers (8) had gone so far as to report 44% of their patients had become normal drinkers at the time of follow-up. Heather and Robinson inferred from these findings that normal drinking should be accepted as a legitimate and intentional goal offered generally to alcoholic patients. Far from accepting Davis’s original position that the therapist should stay in the traditional rôle, Heather and Robinson were very willing to see normal drinking as an entirely reasonable alternative for the therapist to prescribe. In the new dawn, psychologists would be able to teach recovering alcoholics to drink comfortably and without return to problem drinking. The authors accepted that there was still some uncertainty as to which patients might in the long term do best in that direction.

Heather and Robinson’s final conclusions moved beyond the inferences of Davies’s findings and reached for a radical recasting of the treatment enterprise. They called for a root and branch revolution in understanding what alcoholism was, the very “itness” of it. No longer was it possible to see it as a mysterious and innate disease that invaded an individual’s constitution. Now and for the future, declared these authors, the essence of the problem was behaviour which could be eliminated by the cunning interventions of the behavioural psychologist.

This conclusion was well argued but with a polemical edge, and with a hint almost of messianic fervour. The book’s closing sentences seemed to enshrine a wish to recast deep societal values and ideas:

“... we do believe that an exclusive abstinence requirement is a reflection of “abstinence ideology”, and that this ideology is embedded in moral attitudes to drinking in our society ... it is quite possible that good reasons for temporary abstinence have been caught up with moral fervour to be transformed into bad reasons for permanent abstinence. Surely anyone who has

worked in the alcoholism field for any length of time cannot fail to be impressed by the ... moral undertones which seem to pervade the field. Through its association with religion ... the exclusive demand for abstinence is a fundamental expression of the Protestant ethic ... the sooner we emancipate ourselves from the moralistic legacy of the past, the better" (7, pp. 257–58).

And with that resounding last sentence these two psychologists set out their manifesto for their own latter-day moral crusade.

Davies retires into temporary obscurity

Davies wrote the preface to the Heather and Robinson book and commended it as a strike against "the dead hand of Victorian moralism" (7). Over the years following the publication of his 1962 paper, Davies contributed to several papers which appeared to confirm his 1962 findings (e.g., 9). However he did not attempt any major research initiatives to follow through his ideas. As he himself put it, he never saw himself as a researcher but as a clinician who published some research (10, p. 248).

Davies retired from his consultant position at the Maudsley Hospital in 1976. He then set up as director of the Alcohol Education Centre in London, which he established in a Victorian townhouse on the Maudsley campus and which was funded by the Department of Health. He also at this time set up in private practice.

Over these latter years I continued to value Davies's friendship, but on a much more relaxed and informal basis than his early days when I had been a young registrar imbibing wisdom at his ward rounds. It had, I believe, by then become an affectionate relationship. There was particular enjoyment in listening to Davies's aghast accounting of the atrocities perpetrated long ago by some of the important figures in British psychiatry. We were on first-name terms which would have been unthinkable in a previous era. His portrait was hung in an honoured place in the Institute's library.

One of Davies's "normal drinkers" fortuitously comes my way

In 1967 I had established an NHS alcohol treatment service with outpatients seen at the Maudsley and a 12-bedded inpatient unit at the Bethlem Royal Hospital. Over time the service expanded to about 300 new patients seen each year. We provided an essential research base for the Addiction Research Unit (ARU), and appropriately qualified members of the ARU gave support to patient care. Here was a wonderfully potent formula for integrating academic and clinical activities. I personally became aware of the healing pleasure in conducting a busy ward round and hearing patients talk about the realities of their lives, when academic life needed that kind of refreshment.

In the early 1980s a 74-year-old retired shopkeeper came to my outpatients. He seemed to have spent much of his adult life suffering from alcohol dependence of the severest and most destructive kind. He had recently been hospitalised elsewhere with Wernicke encephalopathy.¹ Notes were available to me which showed that he had been admitted to the Maudsley under Davies's care sometime in 1950. Looking through the case file, I chanced upon an astonishing historical document—in 1961 there had been filed away a follow-up report by Davies's Psychiatric Social Worker (PSW) who had at that time provided information which seemed amply to confirm that this man was a case of return to normal drinking. The derelict drinker sitting in my consulting room was undoubtedly one of Davies's famous seven recovered alcohol addicts who had allegedly gone back to normal drinking. The case note evidence seemed to suggest that this man had returned to compulsive drinking by 1955 and over the last six years of Davies's follow-up research. A hospital note of 1958 describing him as having four double brandies and two Guinnesses on a drinking

¹ A potentially life-threatening neurological condition caused by thiamine deficiency and characterized by nystagmus, ataxia, and confusion.

occasion was inconsistent with the claims made in the 1962 paper. It further transpired that during Davies's follow-up period this patient had been attending Davies's Maudsley outpatients and had seen a senior registrar for help with a relapsed drinking problem. This news did not get through to Davies who was blind to this intelligence when he wrote up the case for publication.

With this man's intellectual functioning handicapped by his irreversible alcohol-related brain damage, I took a history from his long-suffering but still caring wife. I read to her the account of normal drinking as given by the PSW after the home visit. She seemed to have good recall of that occasion. She remembered her husband as being as usual drunk that day. He had retreated to the back of the shop but not before threatening his wife with violence if she told the PSW the truth about his drinking. Understandably, she lied to the caller.

I felt deeply perplexed by my encounter with this patient and the accidental, and not very welcome, crossing with the path of history. I remember that I immediately reported this story to Davies whose response was "you can't blame me". When I suggested to him that we might together attempt a later follow-up with all seven of his subjects, he said he had no record of their names and that they would probably be untraceable.

It so happened that shortly after my meeting with Davies I found myself for some reason visiting the long-abandoned office which had once given space to Davies's follow-up secretary and her record system. Previously locked cupboards hung open and piles of paper had tumbled to the floor—the glory days had gone and one was in the presence of wreckage. By sheer luck, a little cross-referencing, some shaking of dust off my clothes, and I had the names and hospital numbers of all seven of Davies's cases grasped in my hands.

At this juncture very worrying news reached me that Davies had been admitted to hospital with cancer. He told me that the chemotherapy was worse than the illness but he still managed to put in some appearances at his old campus. I did not think it was an appropriate time to discuss his normal drinking paper. On

Davies's death on 24 October 1982, I felt honoured to attend his memorial service.

In 1983 I attempted to repay something of my debt to my old teacher with an obituary published in *The British Journal of Addiction* under the title "D.L. Davies: A man of great influence" (11)—I believe that title was apt. I commented particularly on his influence as a teacher:

"...[his] teaching on alcoholism introduced Davies's registrars to the belief that alcoholics were a fit subject for study and that alcoholics were deserving of help. There was nothing arcane about the subject as Davies taught it. Without any attempt at proselytizing the direct impact of that teaching was, however, to put alcoholism on the British academic map" (11, p. 98).

I also wrote about my personal experiences as Davies's registrar:

"Woe betide the registrar who had not bothered to obtain the views of an independent informant or who had written a careless case formulation—Davies seldom betrayed great irritation, but would go into a state of agonised withdrawal ... Someone once remarked that he had the clinical acumen of the best sort of old fashioned family solicitor" (11, p. 98).

Shortly prior to Davies's death I began to explore whether the further follow-up of his seven patients was going to be in any way feasible. I suspected that after a twenty-year gap the majority would be dead or untraceable. I set up searches for hospital and GP records which proved to be invaluable sources of hard information. When I had a patient's address I made a personal call and conducted probing assessment interviews with the patient and separately with the wife where possible. Only one of these men had died by the time of my enquiries but here there was useful information provided by the wife and the records. One of these seven men did not want to meet me but I got information by telephone and again also from case notes. On the whole I was kindly received by people who owed me nothing.

Some of these encounters were remarkable for their intensity and strangeness. A long-retired army officer assured me that he had continued with normal drinking during the years of Davies's follow-up and ever since. A records search confirmed that at the time of our interview, he was attending a day centre for help with his drinking problem. On the way upstairs when I called at his lodgings his landlady whispered to me "Poor gentleman, I always know he is in bad trouble again when he starts hiding his empty whisky bottles outside in the bin."

In brief, my findings as they slowly emerged with much cross-checking of dates and sources were as follows. There was irrefutable evidence that five of Davies's seven patients had experienced significant drinking problems both during the period of his original follow-up and subsequently. One of the seven had been misdiagnosed by Davies as an "addict" and it was unsurprising that he had established control over his drink after some situational difficulties had been dealt with. He and his wife generously asked me to lunch in their elegant retirement home, and they each had a glass of wine with the meal. For just one of the seven patients I could not refute the claim that a dependent drinker had "returned to normal drinking", but he offered me a drink of whisky when I called mid-afternoon to interview him and refused a blood test.

With these results to hand, I felt they were of sufficient importance to deserve putting into the public arena. I felt that I would be guilty of professional misconduct if I were to keep these findings to myself or merely circulate them to a few colleagues. A draft report was prepared which made it very clear that no personal criticism was being made of Davies's integrity. I ended this paper by saying:

"We are after all still not far beyond the beginnings. There is no good reason to believe that return to normal drinking is impossible or improbable".²

² A slightly edited version of this statement appears in a later published version of this draft report. It reads: "We are after all still not

I believed that the report would not impugn Davies's integrity in any way even if with hindsight the data reported in his 1962 paper were unreliable. On the other hand, with such uncertainties as to the sharpness of our case definitions, the soundness of our methodologies and the value of our theories, it would be unwise to claim that return to normal drinking among "alcohol addicts" was either a common occurrence or an easy treatment goal.

I did not at this point turn back from the belief that the inevitable dictate of science was that I had to report these findings in a journal but I was apprehensive that some colleagues might see me as criticizing Davies when he was no longer able to defend himself. Before going further I therefore decided to show my draft report to a number of senior academic figures in psychiatry, and ask for their views on the matter.

I consulted firstly with two very senior and experienced psychiatric researchers and their consensus view was that with some minor amendments my paper should be submitted to a journal. It was cheering to have people in whose judgment I much trusted sending these reassuring messages.

From some other senior figures of British psychiatry whom I consulted at this time, I was however shortly to receive responses equivalent to considerable buckets of cold water thrown into my face. One of these colleagues told me that if I were to publish this paper I would on the instant damage my reputation beyond all remedy and for the remainder of my working life. I should expect to achieve instant pariah status. The second person, someone who at the time held a senior academic position at the Institute of Psychiatry's organisation, told me that I should leave Davies's research to him and just get on with my own research. By another academic I was told that by criticising the former Dean of the Institute I would be bringing the Institute into disrepute and would

far beyond the beginnings. There is no good reason for claiming that return to normal drinking is impossible or improbable, either spontaneously or with treatment" (12, p. 190).

make myself a candidate for dismissal for gross misconduct, with forfeiture of my university chair the appropriate penalty.

I finally sought the views of Davies's widow, Marjorie, who had herself achieved professional distinction as a consultant anaesthetist. Her response was unequivocal. She said that Davies himself would have wanted to see my paper published. And so in 1985 and some twenty-three years after Davies's report had appeared in the QJSA, the same journal, now appearing under a slightly different title, carried my paper, "A later follow-up of a classic case series: D.L. Davies's 1962 report and its significance for the present" (12).

So what is there to learn from this particular story?

All life is a learning experience, I comforted myself by reflecting at that time. I suppose I may be even more intensely aware that most research, including my own, will only ever offer an approximation of the truth and should never be given the status of tablets of stone. I was forced again to the realisation that science is a difficult business with openness to refutation the highest law, the final arbiter, and the fate probably awaiting most of us in the longer term. From the colleagues who supported this paper's publication I derived comfort. From the comments of the three colleagues who would have liked to see my findings suppressed, I learned how important it is for the academic world to honour ethical principles which are never negotiable or to be negated by supposed institutional interest. And I was left feeling that Marjorie Davies's response, with its manifest integrity, had given me something beyond compare.

How was it that Davies as a remarkably astute clinician and a man of great innate caution come to be misled? In retrospect one could say that he was incautious not to have checked all the medical records but that was not necessarily the expectation of the time. Science, this story tells us, is seldom about moving in straight lines of advance.

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Editors' Postscript

Ten years after Edwards's later follow-up of Davies's famous seven patients (12), he wrote an account of how the paper evolved and what significance it had at the time (13). The reader is referred to that paper for additional information about this controversial series of studies. That paper was initially submitted in 1993 to the journal *Addiction*, formally called the *British Journal of Addiction*, of which Edwards was then Editor-in-Chief. According to *Addiction*'s internal policies dealing with conflicts of interest, papers submitted by senior editors at the journal were to be independently managed by other members of the editorial team, a responsibility that fell to the editor of the current book (TFB), who at that time was *Addiction*'s Regional Editor for the Americas. The manuscript was sent to two reviewers, both of whom were very conversant with the controlled drinking controversy. Both reviewers recommended rejection of the manuscript, in my view based on an inadequate interpretation of its aims and possible bias in their opinions about controlled drinking. Given the unanimity of the reviewers' recommendation, I decided to reject the paper, mainly to avoid the appearance of a conflict of interest in the internal operations of the journal. I explained this to Griffith Edwards in a letter that I handed to him as we exited a taxi cab on a raining evening in Toronto, where we were both attending a meeting at the then Addiction Research Foundation. After he read the rejection letter, all he said was "I agree with your decision." The paper was soon revised and re-submitted to *Drug and Alcohol Dependence*, where it was readily published.

CHAPTER 4

Learning from Patients

Interviewing a patient, as we were taught it in our training days, was envisaged as a strictly one-way process. The patient was to tell us everything, while we remained inviolate. We were enjoined to keep our professional distance and “not to become too involved”. Family photographs were removed when we were seeing a patient in our private office.

But about ten years into this work I began to realize that a mysterious and unexpected process was afoot – our patients were in some deep way informing my own inner awareness of life, my awareness of pain, my hopes and fears, my understanding of the human condition. A mass of questions as to who I was and might be crowded in unasked from the shadows and I began to realize that having my patients talk, seeing their lives develop, listening to them tell how recovery was made, all that had more than at the margins provided an inkling of what was a possible outcome when I had first sat down and listened to a patient talking my notes.

This book will for the most part focus on external events and public evolutions over time in a professional world of the addictions. But in this chapter I want to explore the all too seldom talked about questions around the inner world of the

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professional traveler. To that end, I will give some case histories before attempting to sum up the nature of the process of learning to which these and so many other people have over time contributed. These case reports are rooted in reality but with details altered so as to preserve confidentiality.

The Dutch Woman

Annelies had grown up in a happy and traditional Dutch farming family that made famously good cheese. She was aged fifteen when the bombs fell heavily on the nearby city and the invading German army came through her village. At first no one knew how to respond but out of politeness people greeted soldiers and even put flowers on the tanks. But invasion was an insult and there was an undertone of hatred and terror.

About a year later two smartly uniformed and very polite German officers knocked at the door and asked to speak to Annelies. They said they were offering good pay and rations to any young woman who would take up domestic duties in a local Officers' Mess. Annelies's parents demurred, argued between themselves, but they decided their daughter would be well looked after and approved the deal. Annelies packed, and the two smart officers drove her off in their car. But when she took up post she discovered that she'd been trapped to work in a German army brothel. The agonized shame experienced by this young girl was extreme, but it was in this house that she was to spend the next four years of her young life. She soon learned that to become accidentally pregnant was probably a death sentence. When in 1944 the allies landed in Normandy and fought their way up into Holland, this was for Annelies liberation of a very personal kind.

There followed a whirlwind romance with a British soldier. In 1946 and recently married, she set off to settle in London with her de-mobbed¹ husband and was before long raising a family. But

¹ A British term for 'demobilized': released from the armed forces.

from early in the marriage this man was frequently beating her up, forcing sex on her, and referring to her as a brothel girl.

In 1965, Annelies divorced this brutal man but he would still often try to break back into the home. It was then that she first came to see me as a patient. I was in the presence of a bedraggled woman who spent the whole hour of our interview silently weeping. She was drinking several bottles of wine each day and was very dependent on alcohol but I did not doubt that she was also suffering from near psychotic depression. Before I could arrange emergency hospital admission she had tried to kill herself by jumping under a moving car.

Fortunately, her suicide bid failed and we had Annelies on our ward for about three months. We were in the presence of a depressive illness which invaded this woman's whole mental being, devoured her, would not let her go night or day. She hated herself and expected of other people only serial betrayal. We put her on an antidepressant and I watched my gifted staff work with this woman towards discovering her worth and goodness. She agreed readily to a no-drink goal. We introduced her to Alcoholics Anonymous. By the time she left the ward she had broken through to a dawning awareness of hope.

I personally took responsibility for Annelies's follow-up, at first weekly and before long, monthly. She was seeing a lot of her family and was particularly close to a grandchild with a disability. Talk when we met included always some catch-up news on other patients, with her capacities of caring and insight evident. She got a job which ideally suited her as a cook housekeeper in a small Kensington hotel. She told me that after some months the hotel's proprietor had said to her, "What's wrong with the servants these days, Annelies – they seem to be a bunch of raving tee-totallers and no one is nicking the brandy." She did not think it useful to tell him that all new staff that she had recruited were members of AA. The hotel staff held an AA meeting in the basement kitchen every lunchtime.

Annelies and I settled later on an annual meeting around Christmastime. There was always the catch-up news on other

patients – everyone kept in touch with Annelies. I was in the presence of a generous, funny woman whose life was made by helping other people. She told me that she was sober always just for today. I never quite worked out the reason for General de Gaulle being her great hero.

Twenty years after Annelies had first come our way, she died of cancer. She met this illness with defiant courage, surrounded by love and giving love.

Memorial to an Unknown Drug Addict

I never met this man but knew him only through numerous case papers that came to me from the defense solicitors who were resisting his claim for £3 million damages relating to a road traffic accident in which he had sustained a severe head injury. At that time I was feeling crowded, jostled, and miserable with far too many referrals of this near-identical kind. Young men and women who were submerged in the world of drink and drugs would get behind a steering wheel uninsured and unlicensed, or climb into the passenger seat next to an obviously intoxicated driver. Seat belts would never be worn. The vehicle would be driven at top speed down suburban roads. There would be an accident for which someone else would be blamed, a crippling injury and a claim then made for lifetime loss of earnings, lifetime care, and probably also for a new bungalow and a periodic new motorcar.

The latest story was likely to merge in my memory with all the other lookalike cases which the lawyers sent along for my opinion. I was left with nothing but the sense of an underworld of drugs, deprivation, and inexorable tragedy. I must admit that around this time I was finding it difficult to bear going out to happy, comfortable supper parties. I couldn't blame people for not knowing anything about this other world but I felt alienated. I just about managed to avoid ruining the evening by ill-mannered and unnecessary insistence that there was another world down the road. So now I will tell the story of Sam.

Sam grew up on a council estate² in southeast London. Both his parents had drinking problems. He was reared with no expectations of regular, productive employment and before long he was involved in the petty delinquency and drug-taking which was the all too likely career path for young people living on this estate. He left school barely able to read a newspaper. He was smoking heroin by the age of seventeen and injecting the drug at age nineteen. The word “deprivation” was not in his vocabulary. Other people mattered to him only as potentially exploitable objects.

Sam aged twenty-two met up with a mate for an evening of partying which moved from house to house. At midnight, and smashed out of his mind with a mix of drugs and alcohol, he got into a car driven by a friend, George. The defendant said that Sam should have known that George was drunk and refused the lift but at this juncture Sam was so high as to be without a care in the world. George was driving at about ninety miles per hour when he lost control of the vehicle, skidded, and crashed sideways into a brick wall. Sam, who was not wearing a seat belt, was ejected onto the pavement, hit his head, and when he was admitted to hospital he spent the next two weeks precariously surviving in intensive care. It was four weeks before he fully regained consciousness. George and one of the back seat passengers were also badly injured, and a second girl in the back seat had been killed instantly.

So at my desk came three heavy files of case papers in front of me, with all kinds of people trying to contribute to the definition of the truth. Sam was suing George.

I perused—a lawyerly word—the numerous expert reports commissioned by either side to this dispute – neurosurgeons, trauma specialists, neuropsychiatrists, clinical psychologists, and an occupational therapist who offered costings for a bungalow. To add to that there were criminal records, ambulance reports, police statements, and then all the GP and hospital records and a

² A form of public housing built by local authorities in the post-war United Kingdom.

bundle of witness statements. And the formal statement of claim, and the comments on that statement from the defense solicitors. All those papers to be gone through; everything told, nothing told.

So I put the papers aside all carefully marked out and dictated my report onto tape. Somehow speaking the story out loud made it all the more real and unbearable. I felt that society should really be on trial with social deprivation the charge. I wanted to burn all the papers and rage. I completed my twenty page report and signed off with a “statement of truth”, which is one of the formalities, and moved on to next business.

The Scottish Laird

Jamie had grown up the child of landowning Scottish gentry. After finishing his boarding school education, he obtained in the 1930s a position in Kenya as a tea planter. That was a job which suited his love of the outdoors and all things sporting. He used to routinely spend his evenings at a game of bridge and the servant would light the paraffin lamp and set an unopened bottle of whisky at each corner of the marquetry table. Jamie secured a commission in the Royal Fleet Auxiliary at the start of the war. He then served for several years as commander of a motor torpedo boat in Burma which did much damage to Japanese shipping. He won a decoration for his bravery and daring.

Come the end of the war he and his family settled back on their land in rainy Scotland to no great purpose. But he took the whisky habit back home with him.

It was in 1965 that I first met Jamie. He had decided to come down to London and see if a Harley Street hypnotist could help him to stop drinking. He stopped alright, but this resulted in his going abruptly into an attack of delirium tremens. He sent for the fire brigade and when they arrived he sought to persuade them that his gillie³ was

³ One who attends a sportsman in the Scottish Highlands. What the patient meant was that a man was under his bed.

stuck under the hotel's bed. By the time he arrived on our admission ward his delusions led him to believe that he was on an ocean liner. He had identified a male nurse as a steward and generously ordered a whisky and soda for both of us.

Jamie wanted to keep in touch when he left hospital and talk about his desperately missing India and his need to conceive of new meaning in life. He did not, however, like the idea of attending the outpatients' department and I agreed instead to meet him in a local café. Doctor and patient, a café table, serious things to talk about, but I was happy when the relationship soon became one between friends. He gave me a book that his wife had written about their days in India. But he had moved on, and was now setting up a well appointed holiday caravan site. So many conversations together about India, caravan sites, his family growing up, life moving on. He would occasionally send another red-faced Scottish landowner down to see me on the night train for help with a drinking problem.

Jamie had a stroke and was largely robbed of his speech. He then discovered a miraculous capacity for drawing in crayons. He would offer incomprehensible words of explanation as to the meaning of the picture. When he died I stood beside the grave with his family and a piper played a lament in the rainy churchyard.

The Girl from Up North

It was 1970. This young woman, Jenny, got herself down to my outpatient clinic, opened her handbag, and took out some tins of stolen baby food. She opened one and sipped. I was in the presence of a performance artist.

"Heroin is against being human" Jenny said suddenly, looking up at me. Conclusive, I thought, the nail hit on the head.

Our meeting was in the early days of the NHS⁴ response to a new wave of heroin addiction. The routine treatment at that time was

⁴ UK National Health Service.

to offer outpatient prescribed heroin, ampoules of sterile water, and clean syringes, and then attempt to respond to the human realities. Jenny responded to this regime and a few months later she was heroin-free and I arranged for her to be admitted to a Christian drug-free therapeutic community down in the leafy countryside. Jenny wrote to me a few times describing her progress, the changes within herself, and the friendships made. When a year later she left the community, she came to see me hand in hand with her fiancé, a fellow graduate from this community.

Over the next few years there were Christmas cards with brief happy accounts of her life and with photos always of a growing young family enclosed. Heroin had been against her humanity but Jenny had established herself as a drug free, loving mother. Christmas cards like hers can so rejoicingly mark out the years. It must have been at about the tenth anniversary of our first meeting that I received at Christmas a ragged packet which had within it what I took to be Jenny's family photo album. All was chaos, with its spine broken and photos scattered loose. There was a smudged Christmas card inside. The message was so confused that I really couldn't comprehend it. Shortly afterwards I had a phone call from Jenny's distraught husband to say that her drinking was viciously out of control.

Jenny died that new year of an alcohol overdose. I tried to give some comfort to her husband, and wrapped up and returned the precious photo album.

The Good Physician

This fifty-year-old physician was easily recognizable when I first saw him as the salt of the earth. Year after year, and unsung, he dedicated his life to the care of his patients. He came to see me unwillingly and on the insistence of colleagues who thought that he was drinking too much. He was not a man who had it within his nature at all easily to talk about himself.

Drink, he said, had crept up on him, one of those things, stupid, he didn't know how it had happened, but he'd deal with it in his

own way. He was in fact heavily alcohol dependent with a regular schedule for drinking from dawn to dusk. He kept drink in the glove compartment of his car, in his briefcase, in his desk at work, hidden around his home. He did not stop drinking and after six months I experienced an acute sense of conflict between my duty of confidentiality to my patient and my responsibility to protect his patients from potential harm. I consulted an immensely helpful lawyer who told me that my overriding duty was to the public good, and that I should report the case to the General Medical Council (GMC). I sat down with my doctor-patient and explained why I was taking this course of action. He reacted impassively. The GMC got their procedures in place which were in essence constructive rather than punitive. The doctor got back to practice after six months of suspension and was then under supervision for two years. He became over time very helpful to other doctors who had drinking problems. Generously, he did not seem to bear me any grudge and he steered several other doctors toward seeing me. It was only much later that he felt able to talk to me about his homosexuality and his terrible, secret perplexity.

An Especially Difficult Patient

We came to believe that we would at any one time always have one especially difficult patient attending our treatment services. So it was with Sean.

He came from a poor farming family in southern Ireland. His earliest memory was of a kitchen dining table with places routinely laid out only for the male wage earners – his father and four older brothers – with dogs and children fed only from scraps handed out by the family elite. “I learned early how to beg and steal and that I was worthless” he told me. The rule of primogeniture meant that he would have no eventual share in the farm. At the age of seventeen he got on the boat to England.

In his early years as a builder’s labourer he would send money back to his mother. Gradually, however, he lost all contact with his family. They were forgotten other than for some lingering hatred

of his father. “My wages were for my beer,” he told me. At age thirty when he married a patient and passive Irish woman, he was drinking up to twenty pints of Guinness every Saturday and looking for a fight when the pub closed.

I first met Sean when he was aged thirty-nine. He talked with pain and fury about the humiliations of that distant kitchen, before telling me that I was corrupt and useless. We struggled on for a couple of years with very little positive achieved and with his drinking for the most part wildly out of control. When his behaviour deteriorated and he started to turn up at appointments drunk and threatening, we set limits and I had on one occasion to send for the police to remove him. He shouted back over his shoulder that he would have his friends in the IRA⁵ come out to the hospital and sort us out.

Then one day Sean came to see me manifestly sober and wearing a new suit and glowing with happiness. He had left his wife, whom he now blamed for the entirety of his drinking, and moved in with a woman who was ten years older than him, and who held a senior administrative position. She had reinvented him as one of nature’s intellectuals, a Brendan Behan⁶ figure.

A couple of weeks later we were having a staff party one evening in my home. A nurse came up to me and put her arm around me. She was crying. She said “You know about Sean. He’s killed himself”. Sean’s girlfriend had found his drunken violence unromantic and kicked him out, and suicide was his revenge.

The Man Who Did Not Give Up

At around the time of Sean’s death I had two other patients under my care who seemed unable to escape from the most desperately life-threatening drinking. One was a publican⁷ in his thirties and

⁵ Irish Republican Army.

⁶ A famous Irish playwright.

⁷ A person who owns or manages a public house or pub: an establishment licensed to serve alcoholic drinks.

the other a schoolteacher in her fifties. They both went on to die of cirrhosis and we tasted failure.

When Joe started to attend my registrar in outpatients, we feared that here was someone else destined to destroy himself. This man was aged thirty, lived with his wife and three children in a council estate down the road, and described himself as a television repairman but in reality his income derived largely from handling stolen goods. He was a heavy, continuous, bloated beer drinker.

The registrar at a staff conference described Joe as pathologically deferential “but as lacking in motivation and deeply hopeless”. I queried the use of the word hopeless, but this young doctor wanted to know how any of us would propose to overcome this patient’s “hopeless habit” of turning up punctually every two weeks and filling the room with self-excuses, thanks, endless apologies, and no steps forward ever.

The staff nurse said somewhat sharply, “You are being pathologically hopeless, aren’t you?”

The young doctor paused, laughed, drew in his breath and said “That is an extraordinarily helpful remark”.

I heard nothing more about this man until about three months later the registrar brought Joe along to meet us at a lunchtime staff group. The registrar said, by way of an introduction, “Joe, I want you to tell us a little of what’s been happening to your life these last few months”.

“My name is Joe and I am an alcoholic” said this man. The story was of his total immersion in AA.

When Joe had finished talking, the staff nurse asked him if there had been any identifiable turning point. “What should we learn from you?” she queried.

Joe answered without hesitation. “Turning point, yes, sure, when my doctor told me I was not hopeless”.

The Years Go Rolling By

I have presented here somewhat arbitrarily a few case histories from a crowded recollection of faces and scenes. It is a story of

people's triumphs but also and not infrequently of tragedy. My responsibility throughout has been no more and no less than to help as best possible. It would be a betrayal to have used these people just to amuse us but I believe that the question this chapter seeks to address – as to the possible cumulative effect that this kind of experience can have on those who dare to try to offer the help – is a legitimate topic for consideration. Psychoanalysts frequently talk about countertransference, but the focus is then usually on the individual case rather than the cumulative impact. I will attempt now a brief summary of what this experience seems personally to have given me. I don't think it's an occasion for too many words or for any kind of posturing, but more for reflection.

First, I believe that this experience has invited an acute consciousness that life rather than being a few still pictures strung together is, in fact, a moving picture show. Life's trajectory is a longitudinal play. We need to comprehend it in those terms. We need to be intensely aware of the dynamics of change, how people can shake off old habits and make new ones. If that is true of our patients, it is true of us also.

Second, I'm aware that I was told little or nothing at medical school about the nature of human courage and the human capacity for resilience. I feel that education was made here by what I have learnt from my patients.

Third, I believe that the clinical experience has turned me toward some reappraisal of where I stand on the balancing of optimism and pessimism. I feel nudged toward optimism but that is lit by a more acute sense of the human potential for tragedy and self-destruction. I did not fully comprehend either side of this truth before I entered this field.

Fourth, I came to realize that my role as therapist was not to make conclusive interventions but to nudge, hint, cheer, congratulate, laugh with, and give hope to my patients. And I need to test my capacity to do genuinely any of those things.

Lastly, I believe that I have learnt to what extent people are made by parents, childhood, environment, the view from a sequence of windows. I need to be able to think my way into multiple, diverse

and individual worlds, to understand more acutely what are the impoverishments, and what the possibilities.

Bad days as well as good days, yes, and no triumphalism. I am grateful I've been changed, and am still now changing as a result of what patients have taught me. In reality most of what has been given to me goes beyond mere words.

CHAPTER 5

The Medico-Legal World

To enter the world of the law and lawyers for a doctor is to tread very different terrain than the familiar pastures of the clinician or medical researcher. At least in the first instance this is a world which the doctor entering upon it is likely to experience as a very foreign land.

Foreign, how so? Fundamentally, everything in law cases is about what happens between two parties, with each of them intensely desirous of winning rather than losing. On occasions it is bare knuckle stuff with the possible outcomes varying between a conviction or an acquittal in a murder trial or in a compensation case, a derisory award as contrasted to a few million pounds of damages. There is no equivalent to such situations to be found in our parent professions. Doctors find out they are not keen on knocking each other down. Enter into this territory and you will be working with lawyers and professionals who have their own rules and ethicality but at the same time are innately partisan. Working with lawyers, you will often find yourself dealing with people of vast experience in their own field. But besides those external facts are all manner of differences in assumptions, language, and symbolism. One will have learned that “counsel” means “barrister” and the “learned

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counsel” words are typically uttered with a little bile. Senior barrister means heavy fees and a longer wig. Lawyers tend to “peruse” rather than read their papers. If I am appearing in court I will need to know whether the presiding judge is “your honour” or “my lord”. The cut of counsel’s suit, the quality of his furnishings, the standard even of the biscuits provided are all indications that this is not home. To the ordinary doctor, the way a court conducts its business can appear to be an indication to act a little mad. How would we react to a hospital round when all the doctors wore wigs, the length commensurate to their ranking?

The scenery is also very different. The invited medical expert is never more than a bit player in the legal world and they would do well to remind themselves that they know nothing of the law and better not get ideas above their stations. But in difficult circumstances the doctor will always do well to remind themselves that their job is to give the best possible unbiased advice to the court, rather than their being sucked into being a hired spokesman or an agent of any party that has instructed them.

My first experience of medico-legal work was in 1963 when I was registrar at the Maudsley Hospital. A young man who was under my care climbed one night up a ladder in the hope of knocking on his girlfriend’s window. Unfortunately, he missed his step and fell heavily into the parental rose bushes. The angry father sent for the police and the shaking and distraught young man was charged with an intimidating list of criminal offenses. The case came on in due time before the local magistrates where I assisted with a plea in mitigation. The sensible and kindly magistrate handed down as sentence a small fine together with some avuncular advice. And much to my surprise the court clerk came over to me as I left and in crisp bank notes provided what in those days seemed a princely sum.

From that starting point, I graduated into an occasional involvement with medico-legal work. I came to enjoy that different world, its challenges and the professional and personal qualities of the lawyers with whom I was dealing. It was sometimes a relief to step out from the complexities of my own research life. We might

for instance be conducting a 20-year follow-up of addict patients while employing complex statistical methods to understand what factors help some people toward recovery. I came to see medico-legal responsibilities as in some ways a haven from long periods of uncertainty, with the average case likely to be completed, yes or no, within about 12-18 months of my first involvement.

As regards financial remuneration, I paid a lot of the money straight over to my research accounts and it was a pleasure to act on occasion *pro bono* in a deserving case where there was no funding for instance, in assisting young people who are being sued for mistakes made prior to seeking treatment of drug dependence. Some money went to selected charities and I was pleased to be able to assist with the re-endowment of a lectureship that had been set up by a grandfather of mine, John McFadyean. He was born in 1856, worked as a Scottish farm boy and went on to become a revolutionary British veterinary surgeon and Professor of Veterinary Science. Particularly sweet in my memories was the fact that when I met with my grandfather he was prone to say “two shillings” and never half a crown.¹

The kinds of medico-legal work in which I have engaged have varied over time. At one point I seem to have become an expert on alcohol-related murders but later I pulled out entirely from criminal work. I became then for a time involved in drug and alcohol related aspects of child custody cases. There too I eventually decided to give it up. Divorce law cases, commercial disputes between business parties, employment law, a court martial in Hong Kong, much of this legal work involved the intersection of drug and alcohol use and accidents, and I developed an entirely civil rather than criminal practice. I also became involved in the defense of doctors and other professionals who encountered

¹ A shilling was a coin used in England from around 1550 until it was discontinued in 1971. The half crown was another historical denomination of British money, equivalent to two shillings and sixpence, or one-eighth of a pound. That too was discontinued about the same time. These words harken back to a bygone era in UK history.

difficulties with professional regulatory bodies because of their substance misuse. What I had become is a jobbing legal practitioner, working with solicitors whom I liked and trusted.

What I will try to do in this chapter is to explore through the medium of selected case histories what appears to me salient features of the medical interface with the criminal and the civil law.

The rough and tumble of the criminal law

The criminal law is essentially a matter of disagreement between the two sides, nothing reflective, not much give and take, and with little time for *politesse*. It was territory in which I was often uncomfortable and it was a happy day when I decided at the end, no more of this for me, ever.

Case 1: Hubris

I was telephoned by a bright female solicitor who was here acting for the defense. She told me that she had heard that I bore a close resemblance to Ludwig von Beethoven – neither accurate nor very professional, I thought. Her client stood accused of a double murder. She next with a good deal of flattering got the name of the brilliant QC² whom she had hired to assist with this case.

A visit was arranged for me to go to the prison to conduct an interview with the man, who appeared to be depressed and terrified. He had the appearance of a good family man and good citizen despite many years having been dogged by devastating drinking. One night he had gone with his wife to a party organized by a cousin who was in the money, and was held on the 6th floor of a pricey hotel. His wife had suggested to him that he was that night drunk already and that they would do well to miss the occasion. No, he said, this would be the party of a lifetime. At the party he had drunk hugely of everything which was to hand.

² QC means Queen's Council, a senior lawyer or attorney, qualified and authorized to argue cases in higher courts.

Come 10 pm he went out to get a breath of fresh air on a balcony. There he met a stranger who he took against, gripped by the neck, and pushed over the railings to meet his death in a fall to the road below. No one had seen or heard the altercation between the two men. One can only surmise as to the drunken and perhaps delusional motivation. Our client was completely drunk since his arrival at the hotel.

On the basis of the lack of any prior bad blood between the two men or any rational motivation for the killing, I felt it would be possible to argue that this man had probably been so drunk at the time of the offense that he would have been unable to form criminal intent. If that argument were to be accepted by the court, a conviction would be reduced from murder to manslaughter, with a much lesser sentence. I had been around this kind of track several times before and believed that my argument had at least a fair chance of succeeding.

In due time I was summoned to the inner temple to a pre-trial conference with the barrister and the defense solicitor (and expensive biscuits). The solicitor had forgotten that I was Beethoven but was lavishly admiring of the QC.

“Well,” said the QC, “I am grateful for Professor Edwards’s legal opinion but I want to try another defense approach entirely. I am willing to argue that someone else was at the party that night who was responsible for the murder. “Oh, that is so utterly brilliant,” the solicitor declared.

The case went to court and my evidence was not called. Her client went down for murder.

Case 2: The Battering Ram

At 3 am one night in a quiet suburban road, the fearful rum-pus was heard from a police squad who were intent on arresting someone whom they believed to be a major international criminal. They had arrived with a battering ram. In no time they had the front door shattered and were spreading out into the house. In one bedroom they found a startled and protesting middle-aged

man. In the other room was a frightened 17-year-old girl sitting frozen in front of her computer. She seemed an unlikely candidate for a criminal matter and she was taken away in handcuffs, the outcome of two years' hard work by a specialized and very computer literate team of police officers that had been set up especially to deal with this case.

I received a call from solicitors for the defense asking as to whether I could see any way in which I could be of help to them. I was hesitant. This was certainly not familiar territory. I would need to be briefed before I could form a view. This call was followed soon after by a conference in chambers. The solicitor phoned me with a QC and a junior counselor. I had no doubt that there were in the room people of high intelligence capable of human sympathy for a young woman who potentially faced a long prison sentence at the very outset of her career.

The story was of a mother who had walked out of the home and had then vanished without trace. The single parent father was loving but found himself unable to sleep every night for months and months. She became painfully withdrawn at school and no longer wanted to ask friends home. Her schoolwork suffered.

At age 14 she was walking up her home street when she noticed a computer that had been thrown into a skip. This was an era when home computer ownership was still rare. Mary, a child of natural probity, asked her father whether it would be alright for her to raid the skip. Curious, he went along the road to look for himself and carried home to his daughter an early BBC model.

This chance finding gave Mary a machine which was the best friend she had so sadly lacked. Assisted by a sympathetic schoolteacher, this young girl gradually acquired outstanding advanced computer skills, and she had star ratings in her class.

The downside was that Mary's dedication to computing became compulsive. She had to do it, more and more, and late into the night with much exhaustion. At interviews she told me tearfully of her fantasy that one day her computer would lead her to a chance meeting with her mother. Somewhere down the line she began to explore the possibility of hacking into high security military

intelligence systems. The secretiveness, illegality, and darkness of this activity, all appealed to Mary in some mysterious way. She was able to hack into immensely sensitive files that she visited. This included Pentagon systems in the USA and MI5 in the UK. But she scrupulously protected her identity.

I told the defense that on reflection I thought it would be possible to argue that Mary's hacking was a product of psychological difficulties and with a query raised as to whether she had the capacity to form an intent or resist reoffending. I thought that one could argue that her behaviour was a type of addiction. The complex legal imputations of this psychiatric formulation were of course not my business but the defense team thought this direction was close to the truth and potentially credible. We talked and talked and argued against ourselves until we had in fact a simple framework of ideas.

I came on to give my evidence on the 4th day of the ensuing trial and listened for three days to the prosecution's evidence. Mary was portrayed by them as a depraved and delinquent threat to national security and the UK's allies, and a drain on the government's time and resources.

On the stand in the witness box I was taken through my evidence very carefully by the defense QC. By the end of his examination so clear were the questions that I better understood what I was trying to say myself and believed that we were really pushing forward a case rather than engaging in excuse making. I directed my answers to the jury but did not neglect to respond to the QC's questions. Now and then I made some eye contact with Mary who was sitting so isolated and child-like in the dock. The judge, whom I knew to be nicknamed "bastard," smiled kindly.

So to Friday and I spent the rest of the day in the witness box being cross-examined serially by senior and junior counsel for the prosecution. They were courteous but remorseless. The essence of their argument was that the Internet was not a drug and therefore could not give rise to a dependence. I was, they suggested, giving them an invented and personal view that no established authority could back me up. At lunchtime the judge invited the barristers

on both sides to lunch in his private rooms. It was reported to me afterwards that he had declared that he had often had psychiatrists talk nonsense in his court but this chap Edwards by any reckoning took the biscuit for stupidity and obfuscation. Back in court that afternoon for further cross-examination, I tried again to direct my answers very directly to the jury while keeping my answers simple and in contact with human reality. In the evening I was in conference again with the brilliant defense team that had helped identify the strengths and vulnerabilities in my evidence.

Monday morning and I was back in court for the re-examination by the defense QC. I felt myself again given a voice and had the structure of my arguments held in front of me. This was a medico-legal partnership at its best. Lunchtime, I was back in my research unit but two days later the defense solicitor phoned me in my office sounding ebullient. The jury had returned a unanimous verdict of “not guilty”. The look on the judge’s face had been grim. Mary was back working for her imminent A-levels.

Follow-up news came some years later. Mary had attained a first class honours degree in computer science and information technology. Too often the criminal courts seem to set about hunting down the accused person as prey and as dehumanized object. Working with that particular defense team recharged my hope, and I remain deeply grateful.

Case 3: Heavy duty at the Bailey

The Old Bailey has an atmosphere all of its own. It specialises in high-profile criminal trials. The barristers involved are denizens of the criminal bar who have often spent a lifetime in these court-rooms and corridors. They are competitive, battle-hardened, and have few optimistic delusions as to human nature. They stake out the public space in little conferences and stare with hostility at passers by. Atop of this building stands the famous gilded statue of Blind Justice. Prison vans come and go while taking waiting defendants to their cells. Press photographers jostle on the pavements and press their cameras against the windows of the vans

and hope for the sneak photo. It is not an atmosphere of goodwill toward mankind.

I had this time been instructed by the prosecution in a case where the accused man was a painter and decorator. Papers had been made available to me but unusually the defense had refused to let me interview their client. The QC acting for the prosecution was young, thoughtful, and seemingly relaxed and not yet at all the usual case-hardened legal professional of this institution.

The rules are that the prosecution always has to give its evidence first. I went into the witness box on the afternoon of the first day. I related the main facts of the case as revealed to me by the papers. Mr. Patrick McCartney had invited his friend, Mr. Perry to his flat for lunch one Sunday for an Indian takeaway. Drinking started at about 12 noon and continued until 9 pm when Mr. Perry staggered upstairs to crash out on a borrowed bed. An account of this orgiastic drinking session was given by a young neighbor of Mr. McCartney. When Mr. Perry made his wobbly way upstairs Mr. McCartney did not immediately follow but set about the washing up and tidying. The forensic evidence was that Mr. McCartney had then taken a sharp kitchen knife from a drawer and had washed and dried it, not succeeding in removing his fingerprints. Armed with this weapon, Mr. McCartney had gone upstairs and had entered the room where Mr. Perry was now lying asleep. He then stuck his knife with some deftness into the right side of Mr. Perry's neck, twisted the weapon for better effect, so as to inflict the maximum harm. The forensic evidence was that Mr. Perry had bled to death very quickly with massive bleeding from a carotid artery.

The defense counsel started his examination with deceptive calm. He asked whether I had all the information I needed to form an opinion or did I feel handicapped from lack of information. I said there were certainly some aspects of this case in which I would have found it helpful to have more information – the background drinking histories of the two men, for instance, their proneness to violence, their relationship with each other. I would have liked to have known if Mr. McCartney had ever previously shown a tendency to be violent when drunk. But despite

those lacunae I felt able to give an opinion to the court. "Summarise your opinion, doctor, so we know what it is" said the counsel, helpfully. And I said that I had given mind to the possibility to this being a drunken, irrational act, which is when alcohol rendered Mr. McCartney incapable of forming a criminal intent. But my impression was that Mr. McCartney had his wits sufficiently about him to select a sharp knife from his kitchen drawer, to carry that knife upstairs, to enter Mr. Perry's bedroom, and to put a knife accurately into his neck, and turn the blade. Sadly, I was forced to conclude that this was an intentional murder and there was no psychiatric defense.

"Right" said counsel and suddenly his whole manner had changed. "So that is your opinion. But what right do you have to give an expert opinion before this court? With no qualifications at all as a forensic psychiatrist, isn't that the fact of the matter?"

Count to five, I said to myself. Stand up straight, keep calm and courteous. I said "you are quite right that I have no qualifications in forensic psychiatry. I have never claimed such experience but my evidence is given to this court based on my status as a general psychiatrist with special knowledge of the actions of alcohol on the human being, and with some forensic experience."

"Oh, come on," hissed and snarled the lawyer. "You must know that the mere fact of agreeing to give evidence at the Old Bailey implies that you know how to address forensic questions. You are intrinsically issuing a bogus perspective, aren't you?" Counsel was by now shouting at me, writhing, his demeanor showing his contempt in the hope of impairing the impetus of the attack.

Then I said "I am very happy to answer your questions but is it possible to leave the matter to the court? I really don't think it is reasonable to accuse me of having a bogus prospectus and I have done my best to answer within the limits of my credentials."

By now counsel was directing at me his uncontrollable rage in a manner resembling method acting. "*Leave it to the court!*" he shouted, "if you have any shame at all you will withdraw." He does not have any shame at all, I thought as the ranting continued even

longer. I noted that there were no comments or questions on the substance of my opinion.

It was the defense QC's job to put me together again in his re-examination. He asked me firstly if I had the expertise to give expert evidence before this court. I said "yes". He then asked whether anything that his learned friend had said altered the expert opinion which I had presented and summarized. I said no.

That was a message in itself. I admit feeling a little shaky when stepping down from the witness box. Even on the most contentious of academic occasions I never experienced this kind of personal assault.

My kindly counsel found me at lunch break and said "don't worry, that was just a display of mock rage; entirely invented histrionics because the man was desperate and had no personal venom against you."

I heard afterwards that Mr. McCartney had been convicted of murder and that the judge had thought it proper to exclude from the jury's knowledge the fact that this man had only recently been released from prison after a long sentence for knife attack.

Case 4: I give up on crime

The day I drove down to meet this client in remand prison where she was being held was memorable for the sweet smell of the cut grass in front of it. A family of rabbits were out there frolicking and nibbling. As I parked the car I thought of who I would be shortly interviewing. The "who" was there on a murder charge. I had been instructed by the team of a defense solicitor with whom I was on friendly terms, and by a young female barrister – no one here was likely to play games or go ape in Old Bailey fashion.

I was taken by a warder clinking keys to a basement interview room. For a modern building this space seemed dark and damp. The 19-year-old girl sat opposite me without speaking a word. She came from a dysfunctional family and since the age of 14 she received little formal education because of exclusions for disciplinary problems

and fighting. What this girl told me with no show of emotion was that she had been standing one evening on a railroad platform with her boyfriend after an evening out drinking. They were having an argument. She gave him “a bit of a heave-ho” and “the silly bugger fell under the train. It was all just an accident and I was a million miles from doing it on purpose”. I said to her “think about this, take your time, answer any way you like. People sometimes tell me that they have daydreams of one day pushing someone under a train. Has it ever been like that for you?” She said “suppose it can be like that for me sometimes but don’t write this down”.

I said “tell me a little bit more about this if you want to.” Speaking slowly she continued “I will want to do away with the person who is annoying me”.

“What sort of person is likely to annoy you?” I asked. “Likely to be a young man. I don’t have these things about women”.

I duly wrote up my report which I felt had to include what this woman had told me about her fantasies of seeing young men off the railway platforms. I did not feel that I could withhold what she had told me not to write down. I was of course aware that these details were not going to be helpful to the defense. So awkward, but I did not doubt that my responsibility was to tell as best possible my sense of the truth. But sadly I had to say that in my opinion fantasies can sometimes become acted out and this woman was potentially dangerous. In these circumstances my instructing solicitor decided to make no use of my report from the case and instruct another psychiatrist. In due time the client appeared in court and was acquitted.

It so happened that I in the recent past curiously had two other reports for the defense who had instructed me on criminal cases. But as to what my ethical obligation was I thought it was sound to consult a lawyer. He was sympathetic, but said “actually, nothing you can do about it”. Under that advice the next time I travelled on a subway I leant against a wall while waiting for the train. And I thought of the rabbits on the prison lawn, and decided that the criminal law was a game I was no longer willing to play. I could be blamed for retreatism, of putting my own comfort before public service, but I felt so much better for that decision.

The civil law

This is the way in which a medical expert is likely to operate in this territory. They will in the first instance be contacted by the solicitor who is instructing them. I would be likely to turn the case down if I were being asked to meet an impossibly tight deadline or if I wanted uninterrupted time to finish writing a book. And I would always be very careful to steer clear of any case which might risk taking me into an area beyond my limited expertise.

If I have doubts after I have said “yes” I would expect to receive a formal “letter of instruction”³ from the solicitor. At best this will be a succinct summary of the case followed by a precise history of the questions that I will be required to deal with. Letters of this kind best speak to the fulfillment of a high and practiced art form. This letter would then be followed by post or special delivery of the case papers. The average for a typical case is probably two weighty files. At the front will be the legal paper, the statement of charges or the civil complaint and the anticipated response as entered by the defense. What is typical of all expert reports are witness statements, employment records, and criminal records if they are relevant. Next are likely to be the hospital and GP records and perhaps also documentation from social welfare services. Sometimes this briefing will considerably exceed the two file average. At the extreme I had 20 files land on my doorstep that were destined for the drawers of a new dedicated filing cabinet in my office.

As to the way of dealing with these papers, different experts will have their own ways of coping with the task. For economy of effort I tend to speed read and insert comments, noted in my report when I am dealing, say, with extensive social notes which are not relevant to my immediate concerns but I know that I am personally responsible and cannot afford to make serious omissions – nothing important must be overlooked. I will expect to trawl

³ A Letter of Instruction is a letter that gives another party an order or the authority to carry out specific instructions. This legal document is similar to the Power of Attorney that grants a party the authority to carry out specific tasks.

through the notes with many marginal scribbles and much use of yellow stickers as markers. Then with my thoughts assembled and the structure of ideas in place, I begin going through the report to dictate the summary section onto tape. My tape recorder is a precious aid.

So far then, slog, slog, with nothing but sharp thought but nothing particularly creative and the feeling often of climbing a cliff-face with one's fingertips. Then to something far more creative and humanly gripping: the account of the interview with the patient and frequently at the same time separately with their partner. These meetings usually take place in my office. At times I have had to travel to distant cities because a client's level of disability had made travel to London too difficult. If, after all, a visit to Manchester is frustrated by the discovery that a supposedly disabled woman has not kept her appointment but is out somewhere "at the bingo", I am apt to be morose.

My belief is that interviewing clients and their spouses is a very special type of human responsibility. People will ultimately find it intimidating, and perhaps antagonistic. It is essential therefore to spend the first ten or fifteen minutes in scene setting, showing a friendly face, and outlining the terms of engagement. I will start by saying something like "please be sure that I am going to treat you with respect and listen very carefully to what you have to say. In return I am going to expect from you absolute truthfulness, okay?" In most instances the interview then goes well, the person being interviewed is happy and engaged, honesty is evident, and at the end of ninety minutes the client will be feeling better and not worse for the experience. Sometimes it becomes evident that someone is not too forthcoming and honest. I have had clients shout at me and storm out of the room. There is the potential for role confusion and I will always try to be careful that I am not this person's doctor or therapist despite the fact that I care, and want to confer with them rather than accidentally cause hurt.

The report has then to be finalized with an opinion section and a summary and conclusions and a sworn statement that I myself have told the truth and am seeking to advise the court rather than

act as agent of the instructing solicitor and that my responsibility is to be fair and impartial.

My average reports run to about 15–20 typed pages but I have on rare occasion written at considerably greater length (I have a respected colleague who often comes in at 100 pages). What so usefully regulates this section of the law is the so-called Civil Procedure Rules (1) introduced in 1999 by Lord Wolf.

What happens next? Sometimes one's report seems to drop into a deep and silent pool. Sometimes a solicitor offers exceptional proofreading of what is written, and there are other occasions when substantive suggestions are made as to the need for further detail and clarity. In my involvement with numerous cases of the Civil Law I've never once felt intimidated or pushed around. I have always felt that I am working within a framework which is civilized and truly intended to serve the public good. In a difficult case the lawyers sometimes may want to arrange for a conference in which expert evidence will be explored and further revisions perhaps made to my report.

In the great majority of cases the opposing legal teams will then meet and try to broker a deal, occasionally practicing a game of brinkmanship by failing to negotiate as the date approaches for the court hearing put in the diaries. But these tactics are an expensive undertaking and lawyers would much sooner compromise than go to trial. It has been a good few years since I last had to stand in the witness box for a civil trial.

So now for some illustrative cases.

Case 1: The inspection pit

When Fred, a 25-year-old motor mechanic got married, he was a good employee and earning a fair wage. One day he was called back to work in the evening for an emergency job. The lighting was poor, he tripped and stumbled into an unguarded inspection pit. He unfortunately sustained a severe back injury which resulted in a 12-month sickness leave and some residual disability which put restrictions on any heavy load bearing. I was asked to give expert

medical evidence while the defendant was denying all responsibility, suggesting that Fred's opiate dependence was the sole cause of the accident. The fact had come out that Fred was a previous heroin addict maintained on a therapeutic dose of methadone, and the claim in the defendant's case was that sedative effects of this drug had caused the accident.

The histories that I obtained from the GP and drug clinic notes, and from his wife, were able to tell me that this was the story of a young man who by age 17 had drifted into a serious heroin habit. Age 20 he was put onto a methadone script and he had up to the age of 28 been continuously on a steady dose of this drug. The clinic had performed regular testing and there was no evidence of any heroin or other illicit drug use since the methadone was started. And Fred was not a heavy drinker.

When I reviewed the literature I could find no evidence that methadone by itself in normal therapeutic dosage is likely to be associated with increased accident recurrence. I was however aware that opiates belong to a class of drugs likely to cause pupillary constriction (hence the classic "pinpoint pupils") and hence an at least theoretical risk of impaired night vision. I said, however, that I did not have the expertise to quantify this kind of risk or assess its possible relevance to the case and advised that an expert opinion should be obtained from an eye doctor.

Although I was raising an awkward issue for the defense, my instructing solicitor accepted my report without demur and showed it to the other side. The case was duly settled between the two parties.

Case 2: Is cigarette smoking a human right?

My advice was sought by solicitors acting for an NHS⁴ special hospitals trust on behalf of psychiatric patients whose illness had been

⁴ The National Health Service (NHS) is the umbrella term for the publicly funded healthcare systems of the United Kingdom.

associated with criminal offending. This firm was one with which I had previously worked and there was friendship to be revisited.

The hospital had recently introduced a no smoking ban throughout its premises. One's first reaction might be to think that this was a cruel infliction on people deprived of their liberty and shut out from the world in a secure hospital. But on closer look the Trust's policy seemed not unreasonable. It would protect health damage otherwise likely to be incurred by people who were often very heavy smokers and had created a nicotine-drenched and tar-drenched environment that would be very dangerous for any hapless passive smoker. But the idea that a policy was needed to protect patients and staff from health damage was challenged by lawyers who had been able to obtain legal aid for a patient who claimed that his human rights had been abused by the denial of access to tobacco and he was entitled to inhale as much poison gas as he chose to in the public spaces. This expensive legal process was thus cranked up and got underway despite the fact that the policy concerns were probably in accord with general NHS initiatives.

The particular issue on which my evidence was sought related to the claimant's assertion that the forced denial to him of tobacco would threaten his already vulnerable mental state and possibly lead to further aggression and acting out on the ward. My belief was that it was difficult ahead of events to prove a negative, that giving up cigarettes would certainly in the shorter term cause stress and discomfort but on the other hand it seemed to me evident from the literature that the physiological effects of withdrawal were limited to a duration of 4–6 weeks. Meanwhile any exacerbation of psychiatric symptoms could be dealt with by adjustment in medication.

One of the pleasures of a case like this was in reading a report of the claimant's expert advisor, a highly experienced, clever psychologist. I learned from what he had to say and felt that we were able to have a fruitful dialogue between colleagues.

It was about three years before our case came before the Court. The judge found for the defendant.

Case 3: The international security advisor

This man was aged 35 at the time of my assessment interview. His professional life was spent mostly in the Gulf States on contract as security advisor to oil companies. The pay was good but at the price of much disruption to family life.

I was asked to advise the defendant (a motor insurance company) in relation to a Road Traffic Accident. Jonathan had while on home leave been crashed into by another car in broad daylight and on an empty road. Poor Jonathan sustained a fracture to his sternum and, allegedly, a head injury.

The reason for my advice being sought was that in a search of the medical and employment records, evidence emerged that Jonathan had a previous history of excessive drinking. The lawyers wanted therefore to determine whether in any degree the claim for compensation might be laid at the door of the previous drinking history rather than being caused by a head injury. With the arrival in my office of massive documentation I got the distinct sense of a cliff to climb. I had previously heard about the development of drinking problems while on dark postings to the Gulf States where alcohol is forbidden under Islamic law. He knew the hazards of that sort of life but had easy access to illicitly imported drink.

My interview with Jonathan was unhelpful. Perhaps because of his security training, he largely refused to answer questions. But with cross referencing between papers the following history emerged. He had been married at age 23 and at that time there had been no whisper of concern about his drinking. But at age 25 when he took up his first expatriate posting, the social life in the evening centred around drink. Five years later and at age 30 he was drinking very heavily when on leave, so much so that his wife was seriously worried and thinking about divorce. Overseas once more, he was referred to the medical officer for advice on alcohol. Liver function tests were indicative of potential damage. Jonathan refused the suggestion that he should stop drinking. "I can control it. Let me have a go," he said. But my impression was that he had then teetered along with his drinking at least intermittently

before the accident when it got problematic. A couple of years after the accident he was not working, having been reported as drunk on duty, and he was just sitting around at home with an open bottle of whisky at his elbow.

There was a difference of opinion between the psychological experts instructed by the two sides in this action. The claimant's expert believed that the car crash had caused residual brain damage; the defense psychologist challenged this conclusion.

So to the nub of my involvement. The claimant's psychiatrist was a colleague whom I knew well as someone of considerable experience and repute. He argued that even if the drinking was probably at times a bit heavy before the accident Jonathan had vastly escalated his drinking over the two following years. This, he argued, was entirely a result of the impairment in self control which Jonathan had suffered because of the brain injury.

I felt that this version certainly deserved careful consideration. I had no difficulty in agreeing that such an injury could lead to loss of personal control over drinking. That much is squarely consistent with the evidence. But on closer review of the evidence I found that my colleague's opinion did not mesh too well with some of the detailed facts.

I felt that the significance of the 10-year pre-accident drinking was being somewhat underplayed. A period of that length in a drink favourable environment and in which the individual's drinking at times caused family problems seemed to me at the minimum cause for concern. It seemed possible the natural trajectory might at least in part account for the post-accident deterioration in control. The reported intake of a bottle of whisky per day two years after the accident was not incompatible with that hypothesis.

But although this alternative explanation seemed reasonable, my feeling was that the views of my colleague who was instructed by the other side were also eminently reasonable. I was reaching toward suggesting that this was a clear case for splitting the difference and suggesting that 50% of Jonathan's post-accident drinking was on the balance of probabilities due to the accident, while 50%

should be attributable to natural progression. In this kind of work finding a sensible compromise can so often be the way through.

I received at this point a further bundle of notes sent by my solicitor. Not a bundle of such size as to break my back. I sat down for some speed reading and was not expecting anything of tangible psychiatric interest to emerge. I noticed an admission for routine hernia repair a year before the accident event. The admission notes, the operation notes, and the post operative notes all put me in subliminal contact to my distant days as a surgical registrar. I looked from habit very closely at the possibility of the laboratory tests showing up something interesting, but unfortunately no tests relevant to my interests had been conducted. I turned finally to the handwritten nursing notes. An entry for the evening following the operation read “seems to be hallucinating, trying to get out of bed” and “wanting to go along to the mess for a quick snifter”. “Thinks he is inside a building and I am a foreign agent”. This mental disturbance had cleared by the time of discharge five days later. But by that time the solicitor had caught up with what was going on and had written in his notes “query booze”. So far as I could see, this was clinching evidence that a year before the accident Jonathan had undergone forced withdrawal from alcohol contingent on the hospital admission. He had then gone into a state of delirium tremens at that time. The inference was that pre-accident he had already contracted alcohol dependence and such dependence includes susceptibility to experience the withdrawal state which is manifested as delirium tremens. Time and again an attack of DTs is precipitated by a routine hospital admission where such susceptibility exists. In these circumstances I felt that on strong balance of the probabilities the chaotic drinking that followed the accident was straight follow-through of pre-accident drinking which had been made manifest to everyone concerned because it was occurring on home territory rather than the Gulf. This seemed to me a far more credible explanation than the impact of the injury-induced brain damage on self-control. It no longer looked to me like a case of splitting the difference.

Further, as regards the suggestion of significant brain damage, I believe previous drinking needed to be taken into the reckoning. There was no evidence that the experts who had conducted the psychological testing had checked on the level of Jonathan's drinking at the time of the testing. It would be reassuring to see a breathalyzer as routine on every psychologist's desk. The case was settled but my respect for the nurses as astute clinical observers was much enhanced.

Case 4: A mundane case

A mundane case, except no case is mundane. This is the kind of bread and butter case with which courts deal every day and the stock in trade of every hardworking solicitor with offices in a poor quarter of town. A 25-year-old woman, Peggy, for whom life had never dealt a lucky card, got into the habit of drinking the cheapest Italian wine with psychoactive drugs added now and then. She was seeking to regain control of her third child, a 4-year-old boy who had been taken into the care of Social Services because of her alleged substance misuse. The child was the result of a short-term liaison with a boyfriend who was by now entirely off the scene.

At the request of the solicitor who instructed me, I went round to her High Street office and there was nothing expensive or intimidating about her furnishing. She said to me "Don't come in on this if you only like winning cases".

The case notes arrived in my office and ran to the average two files, and the accompanying letter of instruction was very well done. A wonderful capacity for human understanding and sympathy matched to professional confidence.

I extracted the file and then arranged for the client to see me in my office. She failed to put in an appearance. My secretary at that time was gifted in writing sympathetic follow-up letters with no hints of scolding or reproach. The second time I got lucky and Peggy turned up half an hour late wearing a spangled top and leopard skin trousers. I found her a cup of tea and said "so glad to

see you. Please know that this is a friendly place. Take your time and tell me absolutely everything you want me to know about your problems. And I intend to listen very closely”.

In response Peggy talked freely for about forty minutes with intermittent tears. She referred repeatedly to her resentments, to being let down, to wishing that she was dead. She left home when she was very small. Her mother she described as “a lovely lady who drank a bit, and liked men”. Peggy had five children, each with a different father.

The house in which Peggy grew up was in a poor quarter of London and chaos incarnate. Social Services were in constant attendance, nonpayment of rent was frequently followed by eviction, schooling was intermittent, discipline nil, and Peggy was soon living a more or less street life.

Peggy for all intents and purposes left school at 14, and at age 17 had her first child from a man who beat her up. With no boyfriend to look after a child the baby girl was taken into care almost immediately after birth. And that had also been the fate of all three births that had preceded the present treatments. Each event was a carbon copy.

So now Peggy sat in my room weeping with her hands over her face and said “I want the baby, I want to be a mum, I can be a very good mum if only people would leave me alone, get out of my hair and stop hassling me. Fucking Social Services, they just crawl over you!” The story of a life made instantly perfect by parenthood. “Leave it to me to be happy ever after”, she said and she claimed that she hadn’t touched a drop for at least the last 12 months.

My thought at this point was that this woman was a long way away from any kind of reality and I knew from the GP notes that she had recently been drinking. I sensed that she was using me rather than relating to me. The words poured out, threatening other people. I thought of Peggy’s childhood world with shock, guilt, and pain at what my society can do to human beings, or let happen. But one has of course seen people from that kind of background who have gone on to make a better life but by and large that sort of childhood leaves such scars that unhappiness is inescapable.

In my report I suggested that there would be advantage in working with Peggy very intensely on her drinking. Not only was it immediately important if she was ever to regain parental rights, the Court would also feel assured her drinking problem was out of the way. I believed that the experience of mobilizing her resources to deal with the problem and succeeding would be valuable empowerment which would help to resolve other problems. She needed to become a “dealing with” person. I emphasized the need for someone who was skilled in this kind of work, empathetic, and who could help discover in a patient their own ways of dealing. I could think of exactly the nurse on my own team. I said that I would be willing to help and support that nurse if the Court thought that useful. I did not for a minute suggest that all was going to be an easy romp to the winning post.

My solicitor seemed to find this report helpful and submitted it. What happened over the following twelve months was mixed but with distinct improvement on anything that had gone before. There had been slips and failures but Peggy was able to admit to a problem which her drinking constituted and holding herself responsible rather than blaming the world. The local alcohol treatment service had provided a fantastic nurse.

*Case 5. The judge's story: marital abuse when
the drinking wife is the aggressor*

There is of course an extensive literature focusing on a situation where the man has a drinking problem and abuse is directed at the wife and a further well developed literature deals with the children where either parent is drinking excessively (2). There is clinical lore describing the wife getting out of a marriage where her partner is a heavy drinker in order to decrease the risk of her developing a drinking problem. In recent years there has been some improvement in public and professional awareness of the problem set by the still too frequently ignored plight of the woman who is suffering violence at the hands of a drunken husband. Sadly, there has been very little attention devoted to the situation where the man is the victim.

What I intend to do here is to present a case which came my way about forty years ago. I have no records to help me but I believe that my memory is reasonably accurate. My advice was sought by the regulatory body where a county court judge had been reported to them for a flurry of professional mistakes which he had made over the preceding few years. A question had arisen as to whether he might be depressed, and hence my involvement. I have witnessed over the years a handful of similar cases but not sufficient to constitute a case series. There has been sufficient sameness to suggest the possible presence of something syndromic but I am in no position to make that claim. For the present all I want to do is to draw attention to what I suspect is a neglected issue.

The man was aged 54 at the time I was asked to see him. Of Asian origin, he came from a stable family and had been educated entirely in the UK. He had got a scholarship to Winchester, an internationally elite public boarding school, before going out to Cambridge on a law scholarship. There he distinguished himself academically and athletically before taking a first class honours degree in his final law examinations. He came down with, as he put it, the world as his oyster. He passed his bar finals in quick time and completed his year's tutelage in the Middle Temple with a distinguished pupil master. He stayed in these chambers as a junior and built up a lucrative practice in the civil law, despite the fact that in this post war period many of this man's contemporaries could not make ends meet and were forced to leave the bar. He was promoted to QC (Queen's Counsel) with greatly increased fees and the privilege of being addressed as 'my learned friend' at the earliest possible age.

At age 44 he was appointed a county court judgeship in a northern industrial city. This was not the most obvious path for preferment and rumours were circulating that the glitter had somewhat come off his reputation for professional brilliance. Throughout his life the judge had never been other than a very moderate drinker. He had never got drunk.

The birthparents were GPs practicing in the home counties⁵ where her parents had a troubled marriage in that the father had an explosive temper and was easily provoked into violence, directed at his wife and children. At the time the wife had to attend the local A&E department because of her injuries. Both parents were sometimes the worst for drink. As a young girl their daughter was withdrawn and given to temper tantrums. But when she left home for boarding school she seemed to cheer up generally.

The couple met at a May Ball and were married shortly after coming down from Cambridge. It appeared to be an entirely appropriate relationship. She decided to specialize in histopathology, believing that this would be a career compatible with the demands of a family. The couple were delighted when their two sons were born.

The first indication that she might be encountering difficulties with her drinking was in her mid-thirties. She started to get drunk and noisy whenever the couple entertained guests in the evening at home or when they were asked out to dinner at someone else's house. It at first looked like simple indiscretion and she was not drinking every day.

The further progression in the drinking was then quite steep. She was getting drunk every evening whether or not they were entertaining or being entertained. When intoxicated she was likely to be very abusive. She would quite often lapse into a comatose state in an armchair rather than make it up to bed. On occasion she wet herself. Child care was suffering. There was a drunk driving conviction. Sometimes she would be late to work.

He remembered the first occasion of physical violence against him as having occurred on the evening of her fortieth birthday. They had gone out to a five star restaurant and celebrated dinner with prior agreement that the alcohol consumption would not exceed a certain low limit. But she had concealed a bottle of brandy in her handbag and by the end of the evening she was intoxicated. Afterwards as he

⁵ The counties of England that surround London.

held the swinging doors of the restaurant open for her, she hit him in the face with all the force she could muster. He was badly bruised. The husband's response the next day was to guide his wife for the first time toward professional help. She was admitted to a private twelve step treatment centre for eight weeks. She was very critical of every element in the care even as he found the outpatient groups helpful. On return home she immediately opened a celebratory bottle of whisky, got drunk, vilified her husband and put her fist into his face. Over the next ten years the wife had several further admissions for private care followed each time by prompt relapse. She developed signs and symptoms of alcohol dependence and by this time was drinking in the morning. She had received repeated warnings at work and was eventually dismissed. The abuse inflicted on the husband seemed to have almost a stereotypical flavour, verbal abuse every evening and physical abuse more intermittently. In her more sober moments she could be affectionate and apologetic, but she had little real insight into the nature of her problem. A question was raised as to whether she might have sustained alcohol related brain damage but the scan was equivocal.

When at initial assessment I asked the husband about the quality of the help he had received, he said that he had come to realize that he was virtually under the radar of the helping professions most of the time. He described however with wry amusement an encounter with a Freudian therapist who had given the confident interpretation that he was provoking his wife because he craved a victim status. In retrospect, the impact on the husband can be seen as having been manifested in multiple ways:

- 1) An intense commitment to trying to help his wife and self-reproach at the ineffectiveness of his efforts. Throughout these years he never gave up on the attempt to help his wife while shopping around for different doctors and treatment centres. But he could never find any effective way of interdicting the drinking or the cause of considerable guilt. At times he found himself caught up in perplexed rumination on what to do next, and on his failure.
- 2) He became progressively more socially isolated as time went by and this became a problem in its own right. He was very worried lest

his marital difficulties should become a matter of public tittle tattle with the risk that his judicial authority would be undermined. He thought it prudent not to turn to friends for help or comfort and he was reluctant to set up private consultations for himself for fear of who he might meet in the waiting room. He did not see it safe to attend Al-Anon.

- 3) Mood disorder for a good few years. He was experiencing stress and some degree of anxiety. It was difficult to identify the precise transition point when his mental state progressed from discomfort to distinct depression but it seemed to me likely that he had been ill with depression for four years before our consultation. Very sadly his wife had died with an attack of acute pancreatitis about a year before our consultation and the depression had then taken on the characteristics of a grief reaction.
- 4) Impact of the wife's behaviour on the husband's work at interview. The husband readily conceded that the troubles he had experienced at home had impacted on his work performance. He told me that as a judge one needed to be a hundred percent attentive to everything that was going on in court but on frequent occasions he found himself ruminating on what had happened the night before or fearful of what the present evening might bring. This so distracted him that he would lose any focus on the court proceedings.
- 5) Impact on the husband in the round. In sum the impact on the judge was severe and resulted in chronic stress and significant disruption before the onset of depression, and very significant anxiety once he was suffering from depression in a formal sense. Self-blame was throughout a strong feature. The judge himself was restrained in the language he used and in the account he gave of his personal suffering but I was aware that I was talking to a man who had suffered greatly with his chronic stress, which was possibly prolonged and intensified by the social isolation and difficulty in seeking help as he should in his special situation.

Both children encountered psychological difficulties as a result of their home experience. They shared the view that the fault lay entirely with the father and would often add to his pain and complexity by mounting a sustained criticism of their father.

My responsibilities were to provide a report to the best of my abilities for the authority making the referral. I did however see

it as necessary to make an onward referral to a psychiatric team with special expertise in the treatment of depression. My only further contact with the judge was reading his obituary notices which spoke glowingly of his early brilliance but of course made no mention at all of his wife's sad problems. Note: I have altered the case details to ensure the couple's complete anonymity is preserved.

*The medico-legal experience
in the round and in retrospect*

Putting my experience of criminal and civil law and medico-legal practice into the one basket, I conclude that the experience for me has been one of continuous self-education. I have been privileged to see the world through other windows than those framed by my own habits of thought. And I have both enjoyed the company of some clever and human lawyers and learned from the people who have been my clients. I have also learned how sometimes deliberately preposterous are the dubious members of this profession. Yes, taken in the round I am grateful for the opportunity this kind of work has given me to enter a difficult world which has enlarged my doubts and reinforced some of my certainties.

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CHAPTER 6

Addiction: A Specialist Scientific Journal as a Living Organism

Most people will probably live out their happy and productive lives without ever holding a scientific journal in their hands – for them the world of journal publishing is a foreign land. A much smaller percentage of the population devotes, to the greater or lesser degree, a significant proportion of their working lives to the production of these artifacts. A small proportion live, breathe, and eat journals full time. I must confess that for some years I have been at the extreme of that continuum because of my involvement with the journal *Addiction*.

What I want to attempt in this chapter is to give some account of the life and times of this kind of enterprise. It is not about anything fixed in one way in eternity, but about the further reaching after ideas, synergies, and arguments which characterize a creature with a life of its own. The pleasure lies in the worth of what is achieved—participation in teamwork, the service given to a scientific community and now and then a cautious feeling that the journal is achieving more than it did a few years back.

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The rise of scientific journals

The first such enterprise was the Royal Society's *Philosophical Transactions*, first published in 1665, a reflection of scientific activity at the time of the Enlightenment. The 17th century's *Transactions* carried for instance the contributions from Newton, Boyle, and Hooke. Today, as many as 40,000 scientific journals are in publication. In this multi-million pound business the majority of the journals are owned by multinational companies that connect the readers with the scientific community through their publishing enterprises. This is the case with *Addiction*, the first alcohol or drug journal to be owned by a learned society, which has the Society for the Study of Addiction as its owner. In return for deriving profit from the sale of subscriptions, the academic publisher provides payback to support the journal's development and in part to support the Society's activities.

Until recently a major way in which journals survived financially has been through the charges made to subscribers. At present an alternative and increasingly prevalent business model is for a journal to finance itself by fees paid by contributors who retain copyright and also the right to allow "open access" to the publication without the charges levied by commercial publishers.

Addiction, the journal

Addiction has a long history and is in fact today the longest established addiction journal in continuous operation. This story is about the importance of the relationship that exists between a journal and the constituency which it serves. Our first concern will be with the two-way arrows which represent the relationship between the journal and its constituency, the latter characterized here as the 'Invisible College'.

The story of *Addiction* will be explored in chronological sequence, with separate headings for the journal's origins and earliest days, the years from the 1920s to the 1960s, for the period from 1961 to 1978 when Max Glatt edited the journal, and then

a consideration in some detail of the years from 1978 onwards. It will be argued that, building on Glatt's accomplishments over these later years, *Addiction* has, as a collegiate enterprise, achieved a definition of purpose, a scope of activity and a quality of output which are given coherence by a commitment to the fostering of a dynamic interaction with its field. We will look at the stretch from 1978 to the present, first in terms of developments in the organizational framework and changes in the size and complexity of the operation, and secondly in terms of the journal's vision. What in sum will be attempted is an understanding of the *why* and *how* of what has happened to one particular journal over the course of 120 years. How far this analysis might generalize to the life-course of other journals is a question open to debate.

Within the space available, it has been possible only to touch upon the history of the Society for the Study of Addiction (SSA) (the learned society which owns *Addiction*) but accounts are to be found elsewhere of the Society's history (1); nor will any attempt be made to cover the wide background history of scientific journal publishing in general (2,3), or more specifically of medical publishing (4,5).

1884: A journal is born

The starting-point for this voyage of exploration is the day of the journal's birth. If on 25 April 1884 anyone had happened to be passing the rooms of the Medical Society of London, they would have seen much bustle and many impressive carriages arriving: the famous social reformer Lord Shaftesbury was alighting, together with the Bishop of Rippon and a fair sprinkling of titled personages. And 100 members of the medical profession were lining up to enjoy a free meal. The individual whom I can immediately recognize personally in the crowd is Dr Norman Kerr (See Figure 6.1).

The occasion was the inaugural luncheon of the Society for the Study and Cure of Inebriety, and Kerr was the inspirational president of the fledgling venture. With his guests fed, he gave them an address which laid out his stall. A full account of that undoubtedly



Figure 6.1: Norman Shanks Kerr (1834–1899) was a Scottish physician who supported the work of the British temperance movement. He was founder and first president of the British Society for the Study and Cure of Inebriety and he edited the *Proceedings of the Society* from 1884 until his death. Attribution: Unknown author. Uploaded by AndyScott, Public domain, via Wikimedia Commons. This image is licensed under the [Creative Commons Attribution-Share Alike 4.0 International](https://creativecommons.org/licenses/by-sa/4.0/) license. Link to license: https://commons.wikimedia.org/wiki/File:Norman_Shanks_Kerr1.jpg#Licensing. No changes were made.

teetotal occasion and a transcript of the talk that followed (6) is to be found in issue Number 1, July 1884, of the *Proceedings of the Society for the Study and Cure of Inebriety*, published by H. K. Lewis, 52 small pages, price sixpence. Kerr doubled as president and editor. A journal was born which is, today, the longest established scientific journal in its specialized field—*Addiction*.

Over that span of years the journal has experienced six name-changes and there have been profound accompanying shifts in the valence of the two-way arrows.

As Kerr's guests went on their way, they would have had little doubt as to the mission of the Society and the intended function of its quarterly publication. The Society had Temperance connections and Kerr had himself set up a total abstinence society while still a medical student at Glasgow. However, the Society as Kerr envisaged it was intended as a broad church that would bring together in common cause abstainers and non-abstainers. The Society was set up by Kerr and his associates as a body to pressure Parliament toward strengthened legislation on the compulsory detention of people with drinking problems (1). The "better classes" would be sent to Retreats for country-house cures, while the working-class inebriates would be shut away in Reformatories that were prisons by another name. Kerr believed unequivocally that inebriety was a brain disease, as this quotation from his inaugural address shows:

What *is* inebriety? We may define it as a diseased state of the brain and nerve centres, characterised by an irresistible impulse to indulge in intoxicating liquors or other narcotics . . . at any peril. This ungovernable, uncontrollable, overpowering impulse may hurry on the diseased dipsomaniac to his destruction, even when he has no relish for the toxic agent, but on the contrary loathes and detests it (6).

One may note in passing that Kerr was given compulsively to alliteration.

With a disease theory articulated unambiguously decades before Jellinek's *Disease Concept of Alcoholism* (7), Kerr went on to formulate the Society's view on the needed remedy. Total abstinence had to be the treatment goal and no other goal had any chance of success. Some people, said Kerr, might recover without treatment:

As to lay members, there are multitudes whose *morale* has been so deteriorated, whose will has become so paralysed, that they are quite unable to resist the allurements of social custom, or the

strong public enticements profusely provided by our present indefensible licensing system. For such there is but one human hope: seclusion in some home, or on some long sea voyage . . . (6).

Alcohol-free cruise ships were in short supply, so homes it generally had to be.

What can we surmise as to the connection between the *Proceedings* and its readership in those earliest days? In 1884 it was, in truth, probably more a one-way than a two-way relationship, with the *Proceedings* doing no more than print the papers read at the quarterly meetings and the discussions that had taken place around their presentations. Typically, only about 20 people would have been present at a meeting. The *Proceedings* were intended predominantly as an instrument in support of the Society's campaign for compulsory institutional treatment. Membership of the Society was restricted to qualified medical practitioners, but there was a category of lay associates who were not given a vote. The earliest membership data showed the annual subscription was 5 shillings (25 pence in present currency).

The associates added a useful layer of opinion-formers. The Society was at that time concerned predominantly with a British problem and its British solution, but there was a strong liaison with the parallel American society (8) that had been established in 1870, and which published its own *Proceedings*. Indeed, the British society was in many ways an unashamed copy of the American original, and it was the Americans who had pioneered the idea of the asylum as treatment setting for inebriety (9, 10). The American journal ceased publication after the First World War. Prohibition had, it seemed, rendered its parent society redundant.

The Society had a flair for public relations events. Thus, as early as 21 July 1884, the *Proceedings* announced as forthcoming:

Dinner on Diet Reform principles, in the Vegetarian Restaurant at the International Health Exhibition, South Kensington, to Edward Payson Weston, Associate, on his return to America, after the successful completion of his great walk of 5,000 miles, at the rate of fifty miles a day, without intoxicants (11).

The Society here turned a blind eye to the awkward fact that Payson had earlier, in 1876, admitted to chewing coca leaves as an aid to his perambulations (12)—probably one of the first instances of sports doping.

The journal from the 1920s to the 1950s

As one moves along the bookshelves there is a feeling of a society journal having, over those years, somewhat lost direction. The campaign for institutional treatment faded before the First World War and by the 1920s had been abandoned with no other unifying purpose taking its place. That is not to deny the worth and interest of quite a few individual papers. But from 1884 to 1961 the publication, despite the changes in name, continued in the form of a proceedings volume that did little more than reprint papers delivered at Society meetings. As time wore on the meetings seem to have lost their fire and tended towards the perseverative, and whatever the topic there was little evidence of incremental science. Despite some positives, the Society's journal had, by the 1950s, become stagnated. It was insular and with no sense of an Invisible College to which to relate, but only a small coterie of medical practitioners as its supporters. Hardly anything was published that was recognizable as empirical research.

In terms of the two-arrows formulation, one might conclude that in its glory days the journal had been an agent for advancing what the Society saw as a reformist cause, but when that cause died the journal, like its parent society, was left without a purpose. By 1961 there were no arrows at all in evidence. That conclusion is not intended as ungenerous toward any previous editors, but is an accurate assessment of the journal's situation 40 or so years ago. It had become a drain on the Society's resources; it often appeared only twice a year and it was desperately short of material. The editor from 1941 to 1961 was Dr J. Yerbury Dent, a GP who ran a private nursing home for the treatment of addicted patients (1). He advocated oral apomorphine as a cure for alcoholism. Only

the British fondness for lost causes can at that time have kept the Society and its journal in being.

Max Glatt's editorship, 1961–78

In 1961, Max Glatt (13) took over from Dent as editor, a position he held with distinction until 1978. Glatt was a psychiatrist who had obtained his medical training in Germany, but had been driven out of that country by the Nazis. He was of a naturally internationalist inclination and was a keen attendee at the annual Summer Schools of the International Council on Alcohol and Alcoholism (ICAA) which moved around the capital cities of the world (14). He had the idea of picking up the papers given at these meetings and publishing them in the *British Journal of Addiction*. At a stroke the journal's copy flow problem was overcome and its internationalism established. It also became more research-minded in its orientation; and as the funding for addiction research increased in many countries, there was now a greatly expanded field of investigators and policy-minded researchers with whom to relate.

Glatt thus caught and cleverly exploited a tide. There was the core of ICAA material, but he was soon receiving submissions from leading research centres around the world as these institutions developed. There was at the time no other specialist English language addiction journal publishing across licit and illicit drugs. Many people have commented since how much they liked what was referred to widely as 'Max's journal' as a natural outlet for their papers. When Max Glatt gave up the editorship in 1978, the journal had established a relationship with the international world of addiction science and policy that was different from anything his predecessors had achieved. Multiple processes had fashioned new relationships for an old journal.

From 1978 to the present

In 1978 I took over the editorship from Glatt and in 2005 Robert West became Editor-in-Chief. I was told that this was likely to be

a short-term responsibility: the journal was still losing money and seemed unlikely to survive. What follows is an attempt to describe and understand how since 1978 the journal has evolved further. Max Glatt always continued to give the journal generous encouragement up to the time of his death in 2002 at the age of 90 years. He would often telephone to comment in his strong Berliner accent on the journal's progress—no editor could have had more generous encouragement from a predecessor.

Organizational changes

Let us start a review of this last 30–40 years in the journal's further life and times by outlining the external framework for the evolutions that have taken place since 1978.

- *1978, immediate actions at the take-over point.* Max Glatt had never instituted a system of peer review, and seldom rejected a submission. At the time of the handover there was enough accepted material, stored under his desk in several shoe boxes, to fill the journal for the next 3 years. To weed that backlog and establish a peer review process were priorities. An editorial board was put in place. Julia Polglaze gave part-time support on the administration side. She stayed with the journal until 1984, when Patricia Davis took over those responsibilities. From 1994 onwards Patricia was employed full-time by the journal and she was a key player in the journal's evolution and success.
- *1978, Carfax takes over publishing responsibilities.* In that year the journal was approached by Henry Duckett of Carfax, an entrepreneurial Oxford-based publishing house, and he won the publishing contract from Churchill Livingstone to publish on the Society's behalf. Duckett's support was to be vital to the developments of the next few years but, very sadly, he died prematurely in 1994. In 1986, under the pressure of a mounting tide of submissions, the journal went from four to six issues annually. That seemed rational and free from major risk. However, in 1987 the journal made a much more daring move and went from six to 12 issues a year. This meant doubling the price. The nightmare scenario was that we might have misjudged the copy flow and would run out of material, while meanwhile subscribers would balk at the price increase and cancel in droves. In the event,

the copy came in, and only 10 subscribers cancelled; but the thought of going from four to 12 issues a year over just a 12-month period can still make the pulse race.

- *1994, a year of organizational revolution.* The editorial decision was made that for the journal to succeed as an international publication in what was, by then, a highly competitive publishing arena, it would have to shake off the image implicit in the title *British Journal of Addiction* and go for, simply, *Addiction*: a minimalist one-word title in place of the 11-word original of 1884. When this proposed name change was put to Henry Duckett he rushed from the conference room to seize Patricia Davis's telephone and check out the copyright situation. At the same time we made the decision to set up regional offices for the Americas (Thomas Babor), Australasia (Tim Stockwell, then Wayne Hall and from 2006, Shane Darke) and Europe and the rest of the world (Robert West, and later John Marsden). At that time Robert West took important responsibilities as Deputy Editor-in-Chief. We believed from the outset that creativity could be best fostered by emphasizing that the journal would be an enterprise in which all shared equally, and to which all would contribute ideas—that was to be our favoured style of management and it has since worked remarkably well.
- *2002, Blackwell as publishers.* Carfax was taken over by Routledge, which in turn merged with Taylor & Francis. In 2002, after competitive bidding, the publishing contract was transferred to Blackwell Publishing Limited.

Some statistics on performance

The growth in the size and complexity of the operation since Max Glatt sent along to Camberwell the shoe-boxes containing their intimidating load of un-refereed but accepted papers has been vast and, in some ways, like the evolution of a small local business into a multi-national one.

Here are some facts on what has happened to submission rates. In 1979 (the first full year of the new editorial management), the journal received just 69 submissions, of which 42 (61%) were accepted. Across the journal's three offices for 2004, 406 submissions were received, which is just under a 6-fold increase on the

1979 baseline. Meanwhile, the acceptance rate fell to 24%: less than half of the 1979 rate—we have become that much more selective.

The US office alone is now handling four times as much material as came our way in total in 1978, and is by itself a journal-sized enterprise. The US office handles predominantly submissions from the United States and Canada, but also has responsibilities for Latin America; the Australian office deals with Australasia; the UK office predominantly covers Europe, but also with responsibilities for Asia and Africa.

At present, in addition to submitted material, about 30% of the journal's content is commissioned, and the commissioning is a considerable in-house exercise vital to the journal's mission. The commissioning process does much to give the journal its identity and strengthens its active engagement with the field.

Here are a few further summary indicators:

- The annual page length of a published volume has probably risen about sixfold from 1978 to the present. Put another way, the shift has not only been from four to 12 issues a year, but from four to 24 in terms of old issue size.
- The impact of the electronic revolution is seen in the fact that from 1998 the journal has been published online. Readership of online articles stood at 520,800 in 2003. Norman Kerr could never have envisaged that happening and neither did any of us back in 1978. Shoe-boxes and online publication seem worlds apart, but they represent fairly the reality of the journal's quantum leap.
- Blackwell's online-early system allows rapid online publication of accepted papers. In contrast to the 3-year wait for publication that pertained in 1978, *Addiction* achieves citable electronic publication of accepted papers within 8–10 weeks of final acceptance. That is quite some leap, too.
- *The national distribution of accepted papers.* The trend has been towards a decrease in the UK percentage contribution, with an increase in the contributions from the US, Europe (other than the UK) and Australia.
- *Reaching the developing world.* Our publishers are collaborators in an international initiative that delivers *Addiction* electronically to 1,200 centres in 103 of the world's poorest countries each month.

The journal's vision

Let us now turn to the crucial question of vision, and how *Addiction* today tries to relate to the community it serves. That community consists of researchers, practitioners and policy makers world-wide who are concerned with psychosocial, clinical and public health aspects of all types of drug use. What is *Addiction's* 'itness', the ghost in the machine? Journals of one kind give added value to the papers submitted through their refereeing process, but are otherwise essentially passive partners who do not seek to influence their related fields or help to effect any kind of field change. Tear off the front cover and such a journal would be left with no distinct identity. Journals of the second kind, in contrast, derive their authority from the field that they serve, and from the accuracy with which they sense the needs and expectations of that field. They are servants, not masters. But armed with that derived authority they will interact with their field and will dare to operate as agents of change. Journals of the second kind are live organisms. *Addiction* aspires to be a journal of the second kind.

Let us now identify some examples of the ways in which *Addiction* currently attempts to give practical meaning to its vision (15). Table 6.1 summarizes some of *Addiction's* ambitions without the ordering implying priority. That list represents quite a considerable portfolio of visionary intention. Beyond the detail, it speaks to the fact that *Addiction* is, in its being and essence, an intentional type of enterprise—it does not operate by drift. Only a continued process of editorial teamwork and consultation can identify the priority intentions, and with the help of the field ensure that these ambitions are met by publications and debate in the journal's pages (16, 17, 18, 19). The annual meeting of Regional Editors, to which other collaborators were invited, was vital to clarification of this process. The definition of the journal's vision is the work which is always ongoing (20, 21, 22, 23).

The future

This chapter has looked at *Addiction's* life-course since its birth in 1884—the first 120 years of its continuing evolution. It has argued

Table 6.1: Addiction's ambitions as expressed by members of the editorial team.

<i>In my opinion the journal has two major foci. Firstly, of course, the multidisciplinary nature of the journal is a huge advantage. Secondly, the commissioned material is crucial to our unique status. A major competitor has no such observational and reflective component. Something such as For Debate is a venue not seen elsewhere in the literature...</i> <i>The regional structure is also crucial, as we do not simply get a Euro- or Ameri-centric view of the field.</i> Shane Darke, Head of Australian Office
<i>I think there are at least two defining features:</i> <i>1) British origin. The distinctive style of Addiction, from the sharp editorials to Iggy the Iguana have parallels in BMJ, Lancet etc. There is no parallel in style and implicit architecture in other nations.</i> <i>(2) A self-consciously, assertively international journal, again like nothing else in the field. It embraces a world community in a way that other journals (notably many successful USA-based journals) simply do not. I attribute the success of the journal in the long view to being owned by a scientific society and not a commercial publisher. And, at the risk of embarrassing you Griffith, I trace its more recent success to you, who took it from being the British Journal of Addiction to an internationally renowned outlet. Many other people are taking it even further, but there was a quantum leap under your 25 years as editor that was transformative.</i> Keith Humphreys
<i>We hold in our hands a slim book of science each month; a real thing, but Addiction is so much more than object. I feel keenly the link with the long and short history of our journal. I don't think we are inspired colleagues who have nudged the journal forwards to its position today. Yes, it's the great meds and behaviour trials; yes, the policy relevant epidemiology; and yes, the taking a stand on ethics; but it's because we draw interest and material from the best people in our field, surely means we will attract material from the junior faculty tomorrow.</i> John Marsden, Head of UK Office
<i>The British sense of fun and the strong internationalism of the journal distinguish it from all other journals in our field. Addiction is also open to insights and views from a broad range of disciplinary perspectives,</i>

(Continued)

Table 6.1: Continued.

<i>while maintaining a premium on rigour and scholarly value, with a particular interest in policy relevance and impact. The journal reaches a very broad audience which is one of the reasons I like to publish in it and read it.</i>
Wayne Hall, Associate Editor
<i>Being more than just a sausage factory for academic papers – but trying to make things happen.</i>
Robert West
<i>The Journal's essential mission is to promote, develop, publish and translate scientific research into effective clinical and policy applications that will reduce the burden of death, disability and social disorder caused by psychoactive substances throughout the world.</i>
Thomas Babor, former Deputy Editor-in-Chief and Head of American Office

that an understanding of the dynamic relationship portrayed by the two-way arrows is essential for knowing what has happened to the journal up to the present. It is likely that understanding will be vital to the successful shaping of the journal's future. The editorial team will need to maintain and enlarge the relationship between the journal and its Invisible College. As indicated in Table 6.1, members of the editorial team have different views of what the journal should be, but they all agree on the need to serve science and society. Armed with such insights, it will be a yet better journal that can dare hope to strengthen the field with which it interacts, which it serves and which it deeply respects.

It has been an extraordinary privilege to have been allowed to work over some vastly enjoyable years with the journal in partnership with so many good friends. This chapter tries to capture the excitement of those years and identify some of the threads in this journal's long life-course. A journal is an enterprise that needs historical consciousness. Let me end with a personal note: to see Norman Kerr's journal supported so strongly by a gifted editorial team gives me personal pleasure of a very high order.

Tomorrow's work with the journal will ever be likely to give way to complacency. It is a presumption which is as good as the next

month's output. That said, I believe it is a human artifact and a creative act, and to share in this enterprise is a privilege at best deeply rewarding.

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CHAPTER 7

Seeing History: Thomas Trotter (1760–1832)

What do any of us really understand about the impact of history on our family or personal lives? I grew up knowing that my forebearers were small farmers who never scraped together more than a meager living but I don't think I ever understood or much wondered about the political and economic forces which shaped that story. For my secondary education I went to a school which had been established in Elizabethan days to teach godliness and a little Latin to sons of the local tradesmen, but never once in my school days was the deep history of this institution talked about.

In medical training from the first days on the wards, historical awareness permeated our young lives, although the history of the profession was never formally on the taught syllabus. It was impossible not to be excited and inspired by the story of how scientific medicine had emerged, by such heroes as Harvey, by names like Jenner, Florence Nightingale, Pasteur, and by Lister, Addison, Bright, Paget, and Hogdkin who had given their names to diseases. I listened to the country woman tell William Withering (1741–1799) when he was out riding that the foxglove was good for dropsy, and

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felt that I watched Fleming discover penicillin. We were introduced to the wonderfully simple story of the Broad Street pump, and more generally to the history of public health and the willingness of the founding fathers to confront vested interests and the evils of poverty. Somewhat later, psychiatric learning certainly invited historical awareness on a daily basis – Charcot, Freud, Esquirol, Kraepelin, and Bleuler were our heroes then. Further back a retired Cromwellian soldier called Valentine Greotrakes, who offered hypnosis in Lincoln's Inn Fields, inspired my MD thesis.

When my professional interests turned toward alcohol and drugs, all was, comparatively speaking, a historical void. I did not at all know who would have been committed to the Bethlem Asylum a century or two previously with a drinking problem, nor how that problem would have been defined, explained, treated, or prayed over. I did not know what relevant books might have been published over that period. We were suddenly as deeply ahistorical as we had been at my Elizabethan grammar school.

Then in the 1960s by chance a certain book fell towards me—it was called *An Essay on Drunkenness* (1) and had been published in 1804. It was authored by Thomas Trotter, someone I did not at all know. Its antique paper felt good under my fingers. The front page of this volume told me that Trotter had held the MD degree from the University of Edinburgh and was a former Physician to the Fleet. I read as much of the book as possible in ten minutes while leaning against the stacks of an antiquarian bookseller. But at that moment I knew that I was staring in the face of lost history. This was a doctor who was all those years ago writing with enormous insight about alcohol problems and how to treat them. What was more, I was struck by his empathy and his ability to turn a phrase. This man was a stranger to me, but I knew on that instant that I wanted to know him. I was aware also that I wanted to own the book. A pencil mark proved that sometime in the past it had changed hands for eight shillings and sixpence. But the shop was asking £30 for this volume, and that was more than I could at that career stage afford for bookish self-indulgence.

I read and took extensive notes on Trotter in the library of the Wellcome Institute. My access to Trotter's thinking was further assisted when in 1988 Roy Porter, one of the most distinguished medical historians of that time, brought out a facsimile edition together with an informative introduction (1,2). Informative, but truth to tell, I found that that historian failed to appreciate the clinical brilliance of Trotter's writing and went no further toward helping me to understand the life and times of Thomas Trotter.

Thus fascinated by his *Essay* of 1804 but still lacking any real knowledge of the person who had written it, I was aware that when I myself in due time came to write about the treatment of drinking problems, I had Trotter now always as a reference point. In 2007 I published a piece on the *Essay* under a Classic Texts Revisited heading in the journal *Addiction* (2). But there was always the frustration that I was reading a book rather than, in any real sense, knowing the man.

Aware that the Greenwich Maritime Museum was a short distance from my front door, I called one afternoon on the Caird Library. The reading room was all academic hush with a handful of scholars hunched down over their desks. After a long wait, a kind librarian came back with the fruits of her search. She handed me a thin file tied with tape.

When I undid the file what fell onto the table was a collection of letters that had over a lifetime been written to Trotter by important people. There, for instance, was Horatio Nelson thanking Trotter for advice on an infected eye. William Wilberforce, the great abolitionist, wrote to thank Trotter for the valuable support he had given to the anti-slavery cause. Edward Jenner, the discoverer of smallpox vaccination, included, along with his congratulations on the recent publication of the *Essay*, a present of some vaccine. Besides these letters from the good and the great, last in order was a letter which had a different kind of provenance than any of the others. This correspondent enjoyed no high office but had recently been a fellow guest at a luncheon party which he and Trotter had together attended.

Dear Sir,

“I trust you will pardon what I am going to say – A life so varied as yours has been, a person who has seen so very much on board our ships of the line (a scene very new to the literary world itself), a person who can write as well as you can I really do think you should write an autobiography, it only requires a beginning and you will find it the easiest task and most agreeable that ever you took in hand; it will grow upon you imperceptibly. Two or three hours after breakfast will do the business... – you have seen so much on the great deep and of the great theatre of life” (3, p. xi).

That letter was dated 7 September 1829. Three years later, Trotter died. I have lived in hope that at least some notes toward an autobiography might yet turn up, but apart from that one file of letters, Trotter seems to have left behind no cache of papers.

Reading that letter from a fellow lunch guest who had been so fascinated by Trotter’s conversation, my reaction was to feel that a responsibility had unasked come towards me, and that the modern world owed Trotter a debt that had to be repaid. He was owed the story of his life.

I then had an entirely inspired idea come into my head. I talked about Trotter to a good friend and neighbour, Brian Vale. He is someone who had a career as a distinguished official with the British Council, culminating with an appointment as Assistant Director General, but he has also for many years had a productive interest in naval history. One of the attractive traditions of the British Council is the encouragement it gives to scholarship as a byplay of professional service. Unlike myself, Brian holds university degrees in history. What originally attracted him to historical scholarship was a British Council posting to Brazil which by happy chance gave him access to a vast trove of 19th century official papers. Brazil had at that time built its navy by recruiting British officers and seamen who had found themselves unemployed at the end of the Napoleonic Wars. The result was a book published by Brian entitled *A War Betwixt Englishmen* (4). At the time I had this conversation

with Brian he had just finished the book on *The Audacious Admiral Cochrane* (5), a British naval hero as renowned for his lust for personal financial gain as for his prowess as a fleet commander.

With Brian's expert view given that Trotter was from a naval history perspective an interesting and researchable subject, we set up a writing partnership which would aim to give the story of Trotter's life and times and a picture of the man to the world. Brian's knowledge of administrative organization of the 18th and 19th century British navy both at the highest level and at that of an individual vessel's command, crew, provisioning, gunnery, and battle tactics, was inexhaustible. We wrote separate chapters and commented on each other's drafts. This was, for me, from first to last a happy, rewarding and educative experience. Over three years of our joint endeavours we never had a falling out—it was a voyage with no hurricanes or demastings.

What now follows in this chapter will be an attempt to describe what we discovered about Trotter. It is a story of discovery of how the man was shaped by the age in which he lived and by the Enlightenment. It should be stressed that what I am presenting here derives from an exercise in which I was second author while Brian very rightly deserves recognition as senior author (6).

Trotter, Edinburgh and the Scottish Enlightenment

Trotter's father owned a bakery in Melrose, a country town situated about thirty miles from the capital city of Edinburgh. The father had sufficient funds to send young Thomas to the Kelso Academy where he obtained a liberal education and a facility with Latin which was to last lifelong. At age seventeen, in 1777 he travelled to Edinburgh and enrolled as a medical student. There was no entry examination or other formality to be met but a down payment of half a crown was required. Lectures had to be paid for, and money had to be found for frugal bed and board. Edinburgh was at the time emerging as one of the leading medical schools in Europe and had far more practical medical teaching than the

traditional bastions of medical learning at Oxford and Cambridge. There were more egalitarian entry requirements than those costly universities which barred Catholics, dissenters, and Jews from their doors.

One has the live sense of young Trotter becoming inspired by the heady atmosphere that Edinburgh at that time offered. The medical school and its university were permeated by the Scottish Enlightenment and it was said that no one could stand for long at a street corner without the privilege of shaking hands with fifty men of genius. Trotter benefitted greatly from the teaching of William Cullen, a professor who had the great philosopher, historian, and probably atheist David Hume among his close friends, while Adam Smith, the father of modern economics, was one of Cullen's patients.

Trotter would have found in Edinburgh a city with little overt poverty and with a well established professional and merchant class with a taste for dining clubs. It was a city in which many people drank heavily and drunkenness was common. The New Town offered modern elegance even if the high tenements of the Old Town still had their slops hideously thrown onto the pavement each night as the clock struck 10 pm.

In 1778 and with just one year of medical training completed, Trotter had to give thought to his career future. In those days there was no requirement that someone wanting to enter the profession would spend five years or more in study—a year in Edinburgh and then off to look for work was the common expectation. Trotter would have known that to set out in civilian practice would have required capital which was not available to him. The options lay between The East India Company, the army, or naval medical service. Naval service was not particularly prestigious but doctors did not formally hold commissioned rank, and there was thus no need for expensive outlay on dress uniforms and there was hope of prize money when an enemy ship was captured. In the winter of 1778 Trotter followed in the footsteps of many another young Scot to take the London examinations which would give him entry to the navy as a surgeon's mate.

Early Days of Naval Service

A surgeon's mate messed on board with the midshipmen. Conditions were crowded and an ability to maintain good relations with one's peers in cramped circumstances must have been a basic requirement. The surgeon's main duties included responsibility as best possible to maintain a healthy ship. Infectious diseases were rife, as was scurvy on any voyage of over four to six weeks' duration. Accidents were endemic. All these problems together made up the bulk of the surgeon's daily duties. Far more notorious and terrifying, but in reality and with good fortune only an occasional part of the job, was the care of the wounded in battle. Fearful wounds would be sustained by cannon shot and from the shrapnel-like splintering of wood. Surgeons would then be performing amputations without anesthesia. Death from gangrene was a frequent complication.

Trotter's first appointment as surgeon's mate was to *HMS Berwick* which he joined at Portsmouth in January 1779. The vessel had to be refitted and provisioned but in March 1779 it left harbour.

Berwick was a typical 74-gun man of war with a length of 168 feet and a handsome appearance when in full sail. It started with patroling duties in the English Channel, and then set out with Trotter on board for a voyage to the West Indies. By the time the ship arrived in Jamaica, 37 members of its crew were suffering from scurvy. On the voyage home the fleet in which *Berwick* was sailing was engulfed in a hurricane with several ships sunk, and *Berwick* demasted. Trotter was thus early becoming acquainted with some of the dangerous realities of naval service but had not at this point witnessed a shot fired in anger.

That was to change. In April 1782 *Berwick* was patrolling with a squadron in the North Sea. The ship sought to deter Dutch attempts to interfere with British merchant shipping—the Dutch had at that point formed an alliance with Britain's principal adversary, France. At dawning of 5th of April a Dutch squadron came up on the seven British warships. The forces were

about even and the battle hotly contested. After three hours the Dutch broke off and withdrew, with the British in no condition to give chase. The British had in a mere three hours suffered 450 casualties and the Dutch perhaps 100 more. *Berwick* had lost eighteen officers and men killed with fifty-eight wounded. Trotter was by now a surgeon's first mate and his conduct at this engagement was singled out for official commendation. At age 22 he had tasted just about every threat that naval service had to offer and proved himself equal to the challenges.

But in 1783 and with the War of American Independence concluded, there was a temporary cooling off in demand for naval surgeons. Trotter found himself abruptly redundant and with no half-pay or pension. What to do next?

Surgeon to a Slaver

Trotter found employment as surgeon to the notorious Liverpool-based slave ship, *Brooks*. He sailed with her on 3 June 1783. That he should have taken on such an assignment might to a modern day critic look like a lack of ethical scruple. That would, however, be too harsh a judgment. He was never engaged in trading but in providing medical care for the hapless victims of the trade. *Brooks* sailed on the well-known triangular route: Liverpool to West Africa where the slaves were embarked; the horrifying 4,000 mile middle passage to the Caribbean or North America which would take three months if the winds were unfavourable and where there was likely to be heavy mortality from infectious diseases and scurvy; and finally the voyage back to Liverpool.

If any lingering fears should remain that Trotter's reputation was sullied by his service on *Brooks*, the fact that he subsequently gave evidence to a Parliamentary Committee on the slave trade shows him as a devastating witness to the true nature of slaving. In May 1790 Trotter gave evidence to the Committee on three consecutive days and one finds his live voice in the extensive minutes. This was evidence of great value to the abolitionist cause. Trotter's testimony is likely to have carried much more conviction than

that which followed from Captain Noble, the captain and master of *Brooks*. Noble under questioning revealed himself to be a man lacking in humanity and so duplicitous as to caricature himself.

In 1784, Trotter decided temporarily to withdraw from further efforts to obtain a naval position, and instead set himself up as a GP in Wooler, Northumberland and from this base pursued his studies at Edinburgh towards the degree of MD. He attended lectures in Edinburgh and completed a thesis in Latin with the title in translation reading “Of drunkenness and its effects on the human body”. Trotter received his MD degree from the hands of William Cullen in 1788 and Cullen on this occasion saw fit to make a laboured joke in Latin to the effect that the author of the thesis had certainly not been inebriated when writing it. There was polite laughter.

Naval Service Resumed

Having attained his MD, rather than continuing in civilian practice, Trotter decided to return to naval employment. Pitt the Younger, the British Prime Minister at that time, although cutting back generally on government spending, decided that it would be prudent to maintain the peacetime navy at its full strength. In October 1789 Trotter joined *HMS Edgar*, a 74-gun ship then lying at harbour in Portsmouth. He held the rank of ship’s surgeon at £65 per year.

After six months on *Edgar*, Trotter transferred to *Royal William*, the flagship of Admiral Roddam. Roddam had been a neighbour of Trotter’s in Northumberland and in an age of patronage there was considerable advantage to a naval doctor in having caught the eye of an admiral. Trotter at this time saw at close hand the operation of the press gang¹ and observed that on one occasion when 5,000 men were impressed, 500 were so sick that they had to be transferred immediately to hospital [6]. With various

¹ A body of men employed to enlist men forcibly into service in the navy.

alarms and mobilizations, and further voyages to the West Indies, Trotter continued in seagoing service until December, 1793.

In that month he was appointed as Second Physician to Haslar, the naval hospital in Gosport at £200 per annum. This was a fair indication of the growing esteem in which the still young doctor, now age 33, was held. Haslar was built in 1744 and provided a total of 2,100 beds. Nine medical staff were supported by 90 nurses and 24 washer women. A longstanding problem was the tendency of patients to escape over the walls and vanish back into civilian life. Trotter used this posting to write extensively on ideas towards improvements in the organisation of naval medical services [6]—one sees here again his willingness to tackle the larger organisational questions. As so often elsewhere in his life, he showed himself to be a reformer and an interventionist.

In May, 1793, war with republican France had broken out and British admirals decided to appoint physicians to head up the medical services to their respective fleets. These developments were predicated on the belief that this capacity to win naval battles depended very considerably on the fitness of the fleet.

The Channel Fleet was commanded by the heroic but gout-ridden 67-year-old Lord Howe who had reluctantly taken up this command at the request of King George IV. He chose Trotter as his fleet doctor. The physician to the fleet had considerable public health responsibilities put upon him.

In April of 1794, with his new letter of appointment in his hand, the baker's son would have had good reason to believe that hard work had been rewarded with fortune smiling upon him. This was a long way from that early year at Edinburgh and an appointment as Third Mate. In a portrait made of him at this time (see Figure 7.1), he seems a confident young man with a high kerchief setting off his elegant dress coat—he has strong eyebrows and a good mouth.

In April 1794, Trotter was put in charge of fleet medical services in the hospital ship *Chorion* which provided the main medical support for the fighting ships. This was of course the period before the Geneva Conventions. *Chorion* had its own guns but its



Figure 7.1: Thomas Trotter, 1796 engraving by Daniel Orme. Trotter was a physician who studied alcohol dependence and also experimented with the prevention of alcohol problems through policy changes in the British Navy, where he served as Physician to the Fleet. Reprinted by permission. Attribution: Daniel Orme, Public domain, via Wikimedia Commons. Link to license: https://commons.wikimedia.org/wiki/File:Thomas_Trotter_Orme.jpg#Licensing. No changes were made.

safety was essentially dependent on keeping out of trouble and at a distance from any hot engagement.

In June 1773, Trotter witnessed from *Chorion* an engagement with the French which would become famed as the Battle of the Glorious First of June. The British fleet with 32 warships managed to intercept a slightly larger French fleet which was convoying

cargo ships laden with grain from America. This foodstuff was desperately needed by the French people. The French turned to flight but Howe delayed while manoeuvring to get the advantage of the windward position. When he attacked, rather than staying with the expected configuration with the two fleets sailing in parallel and firing their broadsides at each other, Howe ordered his captains to break the line and sail through the French while raking them up their sterns. That way they could pour their cannon fire the length of the French gun decks. The result was devastating.

By midday, six French warships had been captured, one had been sunk, several were severely damaged, and about 7,000 French sailors had been killed or wounded. The British ships sustained a share of demastings but not nearly the damage of the French, and the total British dead and wounded was at about 1,100. The enemy broke off the engagement with the grain ships safely escorted the remainder of the way to a grateful France. And Trotter who would now be vastly busy on board *Chorion* certainly had a grandstand view of an epic naval battle. Something of Howe's humanity and modesty is reflected in the following story. Shortly after the battle was over, a deputation of petty officers begged leave to visit him on his quarterdeck, and congratulate him on a great victory. He answered "No, thank *you*... it is you, my brave boys, it is you, not I, who have conquered." Trotter regarded Howe not only with esteem but with affection. When Howe died, he composed a lament which was published in verse form.

Much of the remainder of Trotter's service was spent on shore and he was handicapped by an injury he sustained when clambering up a ship's side in a high sea to visit sick sailors.

In April 1802, peace with France was declared and the navy was being demobilised. Trotter was retired on half pay of ten shillings a day—that was about what the captain of a battleship would expect, but Trotter regarded it as ungenerous. In July 1800, he was married to Elizabeth Julianna Everitt, daughter of a former naval officer, at the parish church of St. Marylebone. The newly married doctor would have needed to find a way of supplementing his income beyond that pension.

The Newcastle Years

Trotter and his wife moved in 1803 to Pilgrim Street, Newcastle where he set up in practice as a physician. It is difficult to characterize the nature of this practice but in modern terms it might perhaps be seen as having combined aspects of a general practice and a consultant practice. He held no hospital appointment but on two days each week he offered free care to the sick and poor who called at his house. Newcastle with its nearby coalmines was a thriving city, and its Literary and Philosophical Society offered Trotter entry into an active cultural life. But on 1st May 1804, Trotter's wife died ten days after giving birth to their son. Trotter's grief was very apparent but he found ways to cope with parental responsibilities while developing his practice. In 1810, he married Agnes Dixon with whom he had two sons and a daughter.

Newcastle society had seen Trotter become an established figure on the local medical scene, and he gave much further evidence of his literary capacities (6). In 1810 a play of his was performed at the Theatre Royal Newcastle. He wrote a pamphlet on the prevention of mortality in coal mines (1805). He published over these years a book called *A View of Nervous Temperament* (1807). In 1819, there was a book on the manning of the royal navy. And in 1824, he published a volume of his collected poetry.

In 1804, Trotter published his *Essay, Medical, Philosophical, and Chemical, on Drunkenness and its Effects on the Human Body* (1, 2). That was an event of such importance to the scene of addiction as to require consideration in its own right.

An Essay on Drunkenness

This 1804 text was a follow-through to Trotter's Latin doctoral thesis which was itself never published. To have had this book come out in the early days at Newcastle speaks of much late-night industry. One may surmise that the author was keen to make something of a splash and show the world that Newcastle did not mean that he was now off the map and silenced. The book had both

a professional and lay readership as its intended audiences. Trotter confidently asserted the originality of this volume. It is indeed difficult to identify any previous text which dealt with drinking problems in such detail and with such freshness of thought, but the late 18th century had seen a variety of interesting professional writings on alcohol problems. There had been an earlier movement toward viewing habitual drinkers as diseased rather than as moral failures. It would be ahistorical to assert that Trotter in this book “invented” the disease concept of alcoholism.

Trotter’s stance was not anti-alcohol, and he was certainly not a proto-prohibitionist. He described sympathetically the pleasures attending moderate consumption, and he considered wine to be “the milk of old age” – his idea of safe limits was to recommend up to six glasses a day to any drinker at age 60, with that quantity not to be exceeded even if the drinker reached the age of 100.

Trotter’s concern was not with drink but with drunkenness, especially habitual drunkenness. In an epigrammatic phrase, he stated that “*the habit of drunkenness is a disease of the mind*”. This view derived from his belief that habit could indeed become over-learned, ingrained, and distorted. The position he took here was influenced by Hume’s associationist psychology and by Cullen’s medical teaching. Habit was viewed by these authorities as potentially pathogenic. Trotter saw the habit of drunkenness as a disease rooted in habit formation. His immediate inference was that the habit became the doctor’s business. Equally important was his view that it ceased to be clergy business. As he put it,

“The priesthood hath poured forth anathemas from the pulpit; and the moralist, no less severe, hath declaimed against it as a vice degrading to our nature. Both have meant well... But the physical influence of custom, confirmed into habit, interwoven with the actions on our sentient system, and reflecting on our mental part, have been entirely forgotten” (7, p. 3).

The treatment which he recommended for the breaking of the habit was essentially psychological, and in many ways resembled a modern cognitive-behavioural approach. The patient should

be distracted from his dwelling on the next drink, and substitute thoughts and actions recommended. Trotter did not favour institutional care which was to become in the 19th century the vogue in both the US and the UK. He did not make much use of drugs but instead he emphasized the importance of establishing a good doctor-patient relationship. Throughout his treatment, empathy, respect for the patient, and a willingness to work along with that patient, are all much in evidence.

In a passage where Trotter warns doctors about focusing all their attention on the complications of the drinking while ignoring the underlying need to address the compulsivity, he gave advice that is relevant today to clinical practice as it would have been in 1804. He referred to the compulsion as “the evil genius of the habit,” surely as apt and poignant a description as anything offered in a modern textbook.

Trotter in his book comes across as a doctor of estimable quality as well as being an author with a fine gift of expression. Furthermore, we are throughout in the presence of an Enlightenment mind. If I were to be recommending a reading list for any young professional about to enter upon the care of people with substance problems or who were developing an interest in the relevant sciences, I would these two centuries later identify this publication without hesitation as top of any modern day reading list. I would want these young people through the pleasurable reading of this book to feel that they had met Trotter personally.

Trotter as Actor in the Great Theatre of Life

Trotter in 1827 decided to retire from his Newcastle practice and went to live on a small Scottish estate he had acquired at Easter Housepyres, near Melrose. He died age 72, having briefly moved back to Newcastle.

So let's now go back to that letter with its metaphor of the Great Theatre of Life, offered by the fellow luncheon guest. He himself never accepted this prompt to write down an account of all his entries and exits and the multiple roles played.

Looked at objectively his career was one of outstanding and multiple achievements. His contributions to the elimination of scurvy were notable (7). His work on the prevention of smallpox in the Royal Navy was important as was his more general contribution to curtailing the spread of infections on board ship, His attempt to reform the structure of the British Reserve Navy's medical services deserves note. That might have been sufficient for any one actor's professional lifetime. But add to that the prodigious output of written work with the *Essay on Drunkenness* in my view still top of the reading list for any young registrar taking up post at the Maudsley or elsewhere. Take into the reckoning also the play and the poetry. List the scenes witnessed, the people met, the naval and civilian practice engaged in. This was a full life by any reckoning.

Who is the man within this story? Brian and I attempted to answer that question in our final chapter. Even Trotter's most ardent admirers have to admit with his having been now and then unnecessarily contentious, or cantankerous even, and getting into rows for no good reason. Take for instance the occasion when an admiral chose to introduce warm woolen vests as standard wear for all sailors. This idea for some unknown reason drove Trotter into preposterous opposition. But these faults aside, what most characterized this man was his energy, confidence, ability to take people with him, his rationality, his large humanity.

Lest the large score of achievements should mask the warmth of the person, here is an excerpt from a poem (6, p. 204) which a youngish Trotter addressed to a pretty girl who had caught his eye.

Lovely Sue

As beams the moon in yonder sphere,
The clearest and the lightest,
So 'midst the lovely British fair,
My Susan shines the brightest.

On her to look, and not to love,
Scorns all our weak pretences,
Her meanest charms such raptures move,
As ravish all our senses.

A cot I'll rear in yonder plain,
 No hostile arm shall harm her;
 And if she deigns to bless her swain,
 I'll there conduct my charmer.

Brian Vale and I ended our final chapter with the assertion that in the Great Theatre of Life Thomas Trotter was an actor who deserved a curtain call. Hear now please the shouted hurrahs ring out and the vibrant singing of “For he’s a jolly good fellow”.

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CHAPTER 8

Addiction and the Making of the Science/Policy Connections

I have long been haunted by the feeling that scientific libraries are too often repositories of truths that have no public voice. Listen carefully when you next enter such space and beyond the usual academic hush you will hear a low hum which is science trying to break free from its perpetual frustration. The reasons for the difficulty in establishing a fruitful connection between policy and science in the addictions arena are no doubt several. Some of them may be addiction-specific but others are more general. The researchers themselves could be blamed in the past for insufficient effort to synthesize and “translate” their findings in a way which would be likely to engage attention in the public sphere and for too much use of arcane language. Or it may be that science is proffering awkward messages which cannot easily be picked up by policy makers by reason of political imperative or alliance with trade interests. If one moves along these shelves one is however likely to find some exemplary publications which represent honest attempts directly to address this kind of challenge. In the area

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which is the concern of the present chapter, the 1962 report of the Royal College of Physicians on smoking and health (1) provides an immediate instance of science speaking persuasively to the policy makers. The parallel report in 1964 on smoking by the US Surgeon General was similarly effective (2).

Enter the Purple Book

In 1975, a book was published with the absolute and stated intention of giving alcohol science its voice in the health policy world. This slim volume (3) of a mere 106 pages has since been recognized by many people in this field as a brilliant and indeed revolutionary statement. But it has also been viewed as the devil incarnate by alcohol industry trade interests.

How did “The Purple Book” as it is often called, come to see daylight? Its fond soubriquet originated with Robin Room and probably gave it a fair wind. The printed title is *Alcohol Control Policies in Public Health Perspective* (3). The first author was Kettil Bruun, a distinguished Finnish alcohol researcher. Kettil’s name on this publication was followed by a list of ten further participants in this exercise who within the Nordic tradition were listed in alphabetical order with Bruun happily drawing first place both by merit and alphabetically. The more senior partners in this enterprise are however easily identified as having been Robert Popham and Wolfgang Schmidt of the Addiction Research Foundation (ARF) in Toronto. The cast otherwise included five young Nordic researchers who were colleagues of Kettil, a researcher from Hong Kong of considerable ability (Lynn Pan), and Robin Room who at that time was a researcher at Berkeley, California. The more junior participants were by no means spectators and the background discussion was intensely participatory. I was last to join this group although I could claim little relevant research experience.

The joint sponsors of this project were the Finnish Foundation for Alcohol Studies, the World Health Organization Regional Office for Europe, and the ARF. Wolf, Rob, and Kettil already had considerable professional contact and strong shared research

interests and were eminently conversant with the relevant science with important personal contributions. It was noteworthy that the disease concept of alcoholism, an individualistic view of the alcohol problem, was at that time in America the dominant view following the demise of Prohibition (4). I have fond memories of the personal interactions and working circumstances which were a context for the group's work and will give here some notes from that period and its senior actors.

Wolf had been born in 1923 into the Sudetan German community which at that time constituted a significant Czech minority. In the Second World War he had served reluctantly as a conscript in the German army and he described to me the agony of pulling heavy artillery uphill. He was someone of immense depth and humour, and his life story spoke in some ways to a largely vanished Europe. He had attained a doctorate in jurisprudence at the University of Graz, Austria, after the war ended but he then found that no country in Europe was at that time keen to offer him citizenship. Having examined the published international life expectancy data in his young life, he decided to emigrate to Toronto in the belief that this city was capable of longevity. He subsequently told me that his first winter in Toronto was so abominable and the culture so alien that he and his wife talked about a suicide pact as the way out. Fortunately, they subsequently established a happy home in the New World where he moved to a new career and also achieved considerable success as a novelist writing in German about his childhood world.

Kettil was another prime mover of the Purple Book project but came from a very different cultural background than Wolf. He was not someone much given to small talk of matters beyond his scientific interests. He had graduated from a Finnish university with a PhD in sociology (5). He then became involved in the very strong Nordic tradition of social research with his focus before long on alcohol. His pre-eminence in this area was soon evident and from 1955 to 1980 he was Research Director of the Finnish Foundation for Alcohol Studies. Kettil's intelligence, his gift for questioning of ideas, and his generosity contributed both personally and

professionally in a special way to the writing of the Purple Book. When he and I were working together on some chapter we worked without respite until about 10 pm. We would then adjourn to a traditional Finnish restaurant where we would throw back several glasses of spirits in the Finnish tradition.

Helsinki as a backdrop to our meetings, though welcoming, certainly was not a Latin city. There seemed to be memories of a Winter War and a feeling of wartime shortages still operative. A working week when we were billeted at the Rest Home of the Finnish Bank Workers Association was not an enriched environment. There was a view of vast rocky boulders and clumps of gigantic fir trees. Sadly, Kettil died young in 1985 (6). His very apt memorial is the Kettil Bruun Society for Social and Epidemiological Research on Alcohol, which is the international social science forum for contributions to alcohol studies and their debate.

The Voice of the Purple Book

Remember that this book sought to achieve its impact not by any publication of new research findings but by skilled presentation of the then available research base in aid of public health objectives. The core intention of this book was definitely revealed in a passage which appeared in the introductory chapter: "...our main argument is well substantiated: *changes in the overall consumption of alcoholic beverages have a bearing on the health of the people in every society. Alcohol control measures can be used to limit consumption: thus control of alcohol availability becomes a public health issue*" (3, pp. 12–13).

Those two sentences constituted in fact a revolutionary manifesto. For some decades the received thinking in this area had been that the individual's excessive drinking was the problem, with that person's drinking determined by their personality and carried forward by the tide of culture and custom. Geneticists, psychoanalysts, psychiatrists and psychologists were the people with the answers but with a social scientist nowhere in sight. The fact that alcohol was a commodity that was likely to be

responsive to the laws of supply and demand was denied. More than anything, drinking was envisaged as an individual level problem with the disease concept of alcoholism the governing image and with appropriate policy responses limited to the treatment of a sick drinker. The Purple Book's analysis focused on the population's drinking which led the policy response potentially in a very different direction from what had previously been envisaged to the extent that it was the Temperance Movement revisited, but without its absolutism. The book's seven chapters of evidence support its position. Its style was always close to the evidence and never discursive. Chapter 2 focused on a review of reported studies on the effect of excessive drinking on alcohol related disorders. It concluded with a review of evidence showing several strong types of association between heavy drinking and various pathologies, including liver cirrhosis, certain cancers and cardiovascular disease. It cited a report that about half the general hospital beds at that time in France were occupied by people suffering from alcohol related harms. Chapter 3 turned from the individual level analyses to the likelihood of a relationship between per capita consumption and overall levels of harm in the population. It concluded that "...an increase in the per capita consumption of a country should generally be taken to indicate an increasing prevalence of heavy users and of alcohol-related mortality. It should be noted that this prevalence is likely to increase at a much higher rate than per capita consumption" (3, pp. 44–45). The "disease theory" view that alcoholics constituted a small percentage of the drinking population with any increase in related drinking probably being accounted for by some harmless increase in drinking by moderate drinkers was thus disconfirmed.

Chapters 4 and 5 reviewed world trends in alcohol production and consumption. Chapter 6 examined the likely impact of a range of control responses on population-level consumption and concluded that "in many aspects, alcoholic beverages behave like other commodities on the market, so that their consumption is affected by their price level" (3, p. 83). Chapter 7 then looked at the possible benefits which might flow from international agreements

on import and export of alcohol. The book was rounded off with an admirably succinct closing chapter.

And what would any of this today seem to be the significance of the Purple Book? In the years since its publication the book continues to be cited as a source of research hypotheses, policy options and public health theory (6). The alcohol policy world certainly regards this as being a founding text and one of the most influential scientific publications in the field over the last 100 years. And this book has directly inspired a number of successor volumes which we will briefly review in the paragraphs that follow. Figure 8.1. shows the covers of five of those volumes, plus the original, which have attempted to bring addiction science into the alcohol and drug policy arena.

Such is the extensiveness of this output that I will aim for more synopsis than a detailed review of all the science which is



Figure 8.1: Six books that brought science into the alcohol and drug policy arena.

represented in these volumes. I will also seek to present the story line suggesting that in its own right this sequential collection of scholarly work constitutes a remarkable occurrence in the history of addiction science.

The International Study of Alcohol Control Experiences (ISACE)

ISACE was initiated January 1979 as a seven-country policy review exercise (7). Klaus Mäkelä, Robin Room, Pekka Sulkunen, Esa Österberg were among its membership and they shared some core continuity with the Purple Book. This study followed the Purple Book's precedent and did not identify by name the authors that drafted individual chapters but the background case studies understandably named names. Klaus Mäkelä was elected as chairman of an international committee in charge of the project's business. The project again had ARF, the Finnish Foundation for Alcohol Studies, and the European Office of the World Health Organization (WHO) as its sponsors. The analysis focused on the period 1950 to 1976 with some reference as appropriate to the longer term history. The first planning group met in Toronto in 1976 and the report was finalized in 1981. Its output was met with deserved acclaim and in the context of the prior Purple Book it broadened that work's perspective.

In his authoritative introduction to Volume 1 of ISACE, Nils Christie (Professor of Criminology at the University of Oslo) outlined what the project had sought to achieve and his view of its main conclusions.

“Our study is mainly concerned with alcoholic beverage controls – with the state's role in managing the production and distribution of alcohol. The goals of the project were (1) to trace the historical development of alcohol control policy, its determinants, and its effect on the levels and patterns of alcohol consumption in the seven societies, and (2) to assess the potential influence

of control policy on the consumption of alcohol and its adverse consequences" (7, p. 1).

"The alcohol control experiences elucidated in this study provide a window on the overall development of post-war societies – societies whose populations shared experiences in increasing consumerism, more and varied leisure time, and an internationalization of lifestyle and culture. By examining alcohol control, we gained new insights into broad historical shifts – such as the rise in social welfare, mobility, and affluence – and into the emergence of new cultural patterns" (7, p. 4).

The case studies presented in a companion volume (8) emanated sensibly from Poland, Finland, Switzerland, the USA (California), the Netherlands, Canada (Ontario) and Ireland (the latter under the title "Drowning the Shamrock") summed to a masterly analysis of complex and varied policy matters. Nils Christie offered a tail-piece in which he dared foresee the historical trajectory of national alcohol experiences that will be for the future reader to determine whether any of his bets were well placed.

"Looking into the future, one wonders: will that future – if we have any – also be the same for all these countries. I think it can be argued that it will go in that direction. And any further guess would be that we can expect a repetition of a very old history. Several of the cases in this book make it clear that the countries went through a greatly troubled epoch towards the end of the last century. That was the epoch of industrialization without welfare. In that miserable situation, alcohol got a lot of the blame. Political action against alcohol won broad support. Now we are up against new troubles. Chances are that we will enter an epoch of de-industrialization in the seven countries considered in this book. If this does not result in war, it will at least trigger off unrest. The welfare system will become strained. It is possible that this will lead to a renewed interest in alcohol as the cause of the trouble. Drugs are already being used as a scapegoat for the youth troubles created by a social organization that makes youth superfluous to any rewarding task. Alcohol might become the next target and be seen again as a major danger. Which it also is" (8, p. 200).

Alcohol Policy and the Public Good (APPG)

This 1994 volume (9) brought together several participants who were veterans of the Purple Book and in addition some new authors to the membership. The guidelines that the group agreed for conduct of its work were:

- Its meetings would be collegiate and democratic, with the chairperson rotating session by session;
- The group would intensely analyse and discuss individually scripted first drafts of each chapter and work together toward consensus versions as final product;
- The book will consist of unsigned chapters rather than its being a multiple-author edited volume, a formula seen as giving greater authority;
- Participants are invited to join in this work for their scientific expertise and not as representatives of their countries or institutions;
- Facts would be the prime coinage of the enterprise, not rhetoric or groundless speculation;
- No one would be paid for any work done; we had a small financial reserve which could help with travel costs and accommodation when necessary but wherever possible we hoped that people would draw from institutional funding from their employers.

This formula on the whole served us very well. Occasional hot arguments took place within the group among some of the more disputatious people but we were able to resolve most arguments by reference to the facts, and with generosity and humour. And wise counsel came from Cees Goos, WHO's senior staff person on alcohol and drugs, and an expert on consensus building.

Two years of hard work, multiple plenary meetings held in various cities, and the final nurturance of an editorial group saw the book completed. One morning in Helsinki I came down to the hotel breakfast to find Klaus Mäkelä, whom I regarded as the group's unostentatious and invaluable conscience, wrapped in seeming gloom. On questioning he revealed that he had an acute concern that our work would be moving too fast. The Nordic tradition would probably have favoured at least twice our time scale.

The preface to *APPG* (9) acknowledged its debt to the Purple Book. It attempted to take that earlier and crucial statement further forward with a widely expanded research base now available – the reference list for Bruun *et al.* (3) contained 158 items whereas *APPG*'s corresponding listing was of 709 items. While the Purple Book had a 106 page length, the latter document ran to 226 pages. A different era, a richer literature, an expanded team but still with the same form and focus – the analysis of alcohol science in support of alcohol policy. We were trying to talk to our audience and put immense effort into crafting the book's readability.

We then heard that the Portman Group, an alcohol industry lobbying organisation, had photocopied a pirated draft of *APPG* and sent it to six selected persons who Portman thought to be on the industry's side in any alcohol policy debate. At least two of these people received their salaries and research funding directly from the drinks industry. Very fortunately, Nick Heather, an independent-minded researcher unlikely to be bent, copied his letter of invitation to us. We phoned *The Independent* newspaper which seemed very interested in investigating this news (10). Each one of the Portman invitees was offered a free weekend in a hotel for finalization of their rubbishing exercise and an inducement of £2,000. Their names would not be identified on the cover of the book which the Portman Group were proposing to publish and anonymity would be guaranteed. Short of balaclavas this exercise looked more like a conspiracy than an attempt at unbiased comment: the bidding letter was already introduced by describing *APPG* as "biased". *The Independent* ran this story as a front page feature on four consecutive days and the attendant publicity was such that *APPG*'s first printing ran out within a week of publication. I subsequently had the thought of engineering a bogus drinks industry attack on any further books we were writing together but narrowly resisted this temptation.

The English edition of *APPG* sold 3,112 copies and has been cited 966 times since its publication in 1994. Full foreign language translations were achieved into Finnish, French, German, Norwegian, Portuguese, Russian, Spanish and Swedish and shorter versions

were published in Italian and Hebrew. Successful launch meetings were held in several countries with a political and strong press presence. The international journal, *Addiction*, published an extensive summary of APPG with comments from a panel of experts. We were as publicists self-taught and learnt along the way.

Alcohol: No Ordinary Commodity (ANOC)
first edition 2003 and second edition 2010

Both of these volumes (11, 12) were sponsored by the UK Society for the Study of Addiction which derives the greater part of its funding from the journal *Addiction*, with additional sponsorships from the World Health Organization (11) and the Pan-American Health Organization (PAHO, the Americas office of WHO). These books speak to the energy and commitment of our group of alcohol researchers who wanted to take the work of the Purple Book and of previous exercises further forward. The essential formula for the conduct of these updating exercises was that employed by APPG. No one told these people to lay aside their ordinary work or academic involvements to engage in these demanding tasks. There were new recruits to the team who were by now building on considerable experience. The high personal reward must have been considered in some ways useful. The chairman of this group was Thomas Babor, a social epidemiologist with considerable knowledge of the alcohol research and policy fields. The first edition of ANOC ran to 290 pages with 927 references. It has sold 2,801 copies. The corresponding figures for ANOC2 are 360 pages, 1,275 references, and 2,663 sales. Both volumes have been cited over 1,200 times in the scholarly literature.

A particularly strong feature of ANOC 1 and 2 was the presentation of tabulated ratings of a wide selection of strategies and interventions according to evidence of effectiveness, breadth of research support and extent of cross-national testing. These ratings constituted a policy consumer's scorecard directly intended for a place in a ministerial briefcase. Key entries from the ANOC2 tabulation are summarized below in Table 8.1. The table lists the

Table 8.1: Theoretical assumptions underlying seven broad areas of alcohol policy, and the “best practices” identified within each policy area.

Policy Approach	Theoretical Assumption	Best Practices
Alcohol taxes and other price controls	Increasing economic cost of alcohol relative to alternative commodities will reduce demand	Alcohol taxes
Regulating physical availability through restrictions on time, place, and density of alcohol outlets	Reducing supply by restricting physical availability will increase effort to obtain alcohol, and thereby reduce total volume consumed as well as alcohol-related problems	Ban on sales, minimum legal purchase age, rationing, government monopoly of retail sales, hours and days of sale restrictions, restrictions on density of outlets, different availability by alcohol strength
Altering the drinking context	Creating environmental and social constraints will limit alcohol consumption and reduce alcohol-related violence	Enhanced enforcement of on-premises laws and legal requirements
Drink-driving countermeasures	Deterrence, punishment and social pressure will reduce drink driving	Sobriety check points, random breath testing, lowered BAC limits, administrative license suspension, low BAC for young drivers (“zero tolerance”), graduated licensing for novice drivers

(Continued)

Table 8.1: Continued.

Policy Approach	Theoretical Assumption	Best Practices
Education and persuasion: provide information to adults and young people especially through mass media and school-based alcohol education programmes	Health information that increases knowledge and changes attitudes will prevent drinking problems	None
Regulating alcohol advertising and other marketing	Reducing exposure to marketing which normalizes drinking and links it with social aspirations will slow recruitment of drinkers and reduce heavier drinking by young persons	Legal restrictions on exposure
Conduct screening and brief intervention in health care settings; increase availability of treatment programmes	Alcohol dependence will be prevented by motivating heavy drinkers to drink moderately; various therapeutic interventions will increase abstinence among persons who have developed a dependence on alcohol	Brief interventions with at-risk drinkers, mutual help/self-help organization attendance

Source: Table 8.1, Alcohol and Public Policy Group (13). Reprinted by permission. Based on consensus ratings of effectiveness, amount of scientific evidence and cross-national testing.

seven main areas within which alcohol policies have been developed and describes the theoretical assumptions behind each policy approach as well as the specific interventions that have been found to be “best practices” based on the evidence of effectiveness, amount of research support and extent of testing across diverse countries and cultures.

Drug Policy and the Public Good

This book (14) was published in 2010 with an international writing team appropriate for the exploration of the science base in support of effective drug policies. As suggested by the title, the intention of working on policy matters (e.g., the global burden of drug-related harm, the evidence base for drug control strategies and clinical interventions) similar to the previous alcohol-related projects was enhanced by the continuity provided by two Purple Book authors still being present 35 years later in the 2010 team. The project was again ably led by Tom Babor with PAHO and SSA identified as sponsors. Venturing on from alcohol-related questions, the science of drug policies seemed at times like sailing from calm waters into stormy seas. The drug world was dominated by fraught debate and angry position-taking over the question of whether policy should concentrate on a yet more resolute war on drugs or turn to outright legalization of all currently illicit drugs as a panacea.

So what position did the group in the event feel able to take? A “summary and conclusions” offered some specific advice and also identified a number of areas in which the data were too poorly developed to offer confident conclusions about what would likely be effective on a policy level. The group concluded that among the 43 policy options evaluated in this book, 17 were shown to be effective in at least one country, especially options devoted to health and social services to people with drug dependence. Unfortunately, policies that have shown little evidence of effectiveness tend to be the preferred options of many countries and international organizations.

As with the first edition of *Alcohol: No Ordinary Commodity*, this group again attracted the First Prize in the public health category of the British Medical Association's Medical Book competition.

An experiment of nature and its possible future

Researchers in the alcohol and drug policy community use the phrase "experiment of nature" to describe the occurrence of a usefully researchable happening where natural forces rather than experimental intervention have brought about a change in the availability of a substance, with a researcher then stepping in quickly to exploit the opportunity to evaluate its impact. The Purple Book, for instance, reproduced a graph showing liver cirrhosis death rates, 1900–1960 with a short sharp drop in mortality during the years of the second world war, when drink for Parisians was in short supply. Bruun *et al.* (3) considered this as constituting important chance evidence on the relationship between per capita consumption level and harm.

The epithet "experiment of nature" might perhaps with equal aptness be used to describe the emergence since 1975 of the six international projects identified in this chapter. They are not all identical in form or intention and have had varied membership and leadership. But the similarities in their authorship teams, formats and purpose are apparent.

Was this sequential endeavor successful in giving science a voice and public policy a greater impact? The sales figures, citation rates (and gossip) seem to confirm the worth of these endeavors. But we have no controls and independent critical appraisal is certainly needed.

As for the future of this natural experiment, does it need to reach beyond happenstance, friendship and ideas for the next project hatched over some chance meeting? Should we seek to secure the future of this informal and in some ways rather chancy undertaking, give it a name, find it an address and an office, a constitution, and a guaranteed international forward march? How are we to make sure that the best people are continuously recruited and the

taint of cronyism avoided? With the anticipated publication of a third edition of *Alcohol: No Ordinary Commodity*, the Alcohol and Public Policy Project that began with the Purple Book continues to point the way for brighter, younger research workers, allowing them to see what new horizons need to be scanned.

Personally, I am very aware that involvement in some of these projects has provided the equivalent of continuing professional education of a special kind and made me more aware of what science can offer beyond the stacked contents of library shelves. Along the way I have enjoyed much friendship.

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PART II

Travelling Lightly: Viewing the World from Windows Other Than One's Own

Editors' Introduction

Thomas F. Babor

A travelogue is a description of the places visited and experiences encountered by a traveler. The seven travelogues presented in this section of the book describe the benefits of seeing the world through the lenses of different people, places and cultures. They show how differences among nations are diminished by shared understandings and common problems, such as addiction. Most of the travelogues provide an insider's view of how addiction science is understood, applied and conducted. They also describe how the career of Griffith Edwards evolved in relation to the emerging ideas and the global networks that he moved in and in some ways also created. Several of the trips (1955, 1970) have nothing to do with addiction, but they are included because they reflect his early interest in America and India as cultures he could learn from and write about with his characteristic eloquence.

Mark Twain is reputed to have said that "Travel is fatal to prejudice, bigotry, and narrow-mindedness." Griffith Edwards shows why this aphorism is true, and how addiction science has benefited from people who represent different cultural and geographic perspectives on a common problem.

CHAPTER 9

1955: Visiting America¹

The ship was slow, the public rooms crowded. Every morning we crowded round the chart and saw that we had crawled over another inch of the Atlantic. We crowded round the bar, crowded

¹ Editors' Note: This essay was one of Griffith Edwards's first publications, appearing in the *St. Bartholomew's Hospital Journal*, which he edited as a medical student in 1953. When he finished his internship at St. Bartholomew's Hospital in 1955, he traveled alone to the United States, visiting New York and parts of other northeast states known as New England. With palpable irony, he describes the numerous people he met and the different ways they all asked and answered the same question, without ever trying to answer it in detail himself. There is nothing about addiction in this article, but there is much about Griffith Edwards, his facility with words, his interest in people and how he learned from them. This article is reprinted by permission from the *St. Bartholomew's Hospital Journal*, Vol. LX (3), March 1956, pp. 92–94, copyright Faculty of Medicine and Dentistry, Queen Mary University of London. Courtesy of Barts Health NHS Trust Archives.

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into the ship's cinema, smiled and apologized as we crushed each other in the corridors. I shared a cabin with an American oil man and we were thrown much into each other's company. He lay on his bunk and read Toynbee. He was a silent sort of man, never seemed to say much unless he had considered his words for an hour or two. Yet the tie that adorned his neck was not reticent, and would have brought a blush to the cheeks of a Soho spiv;² but he was an educated man who had travelled round the world several times, acquiring an unusual knowledge of European literature and a scholarly interest in jazz.

One day (the eighth day of the interminable voyage and we had clam chowder at lunch), the oil man sat on the edge of his bunk and warned me against the folly of an Englishman trying to make his home in America.

"You Englishmen," he said, "you don't survive in America. America is a country that lacks self-confidence, and the American is an individual lacking self confidence. So every man has to waste half his life making a show, proving that he's a swell guy. An American never settles down to taking himself on trust. There's none of your English self-assurance that allows a man to relax without being thought idle or allows him to be eccentric without being suspect. You stay home, boy."

On the morning of the tenth day at sea, my friend stood by me on the deck, and we watched the sky-scrappers of Manhattan shape themselves out of the mist. I have never seen a city more surprising or more beautiful.

A few days later I was eating rainbow trout in a wayside café. It was only an ordinary dinner, the English equivalent being the café you find by any main road. There was trout and there was turkey on the menu, there was ice in the water, and there were paper table-napkins. An American college girl gave me a lecture on the American way of life, and I was humble, and listened. She had an earnestness about her that was enchanting. She said that it was

² A man who typically makes a living by disreputable dealings, lives by his wits, and is often characterized by his flashy dress.

wonderful that people should have television sets and refrigerators and good food and a college education, and that Englishmen scorned the importance of material things too easily. I listened to her, and for the first time believed in the spiritual value of the refrigerator and I was certainly not laughing at her.

In New York, I got lost. This is supposed to be impossible, as the street numbering is logical in the extreme. However, I landed up in East 114 Street when I was aiming at West 114 Street. I realized my mistake when, after fifteen minutes walking from the subway I had not seen another white man. It was midnight, and I was somewhere in the depths of Harlem. The houses were shabby and decaying, people sitting about on the steps even at that time of night, bursts of music coming from open windows, incredible New York heat, the bars still open and a great deal of life and excitement. Suddenly a voice hailed me from a doorway.

"Hey, smart guy, what you want?"

"I want to get home," I said. Never a truer word.

"When I see a smart guy like you I think you want a woman."

The man who spoke to me was a little negro, with a crushed-in hat, shabby down to his dilapidate sneakers. I gave him a cigarette and we stood in the doorway and talked.

"What do you think of this joint, smart guy?" the negro asked.

A drunken man with only one arm came by, and seeing a white face, lunged at me, swearing. That night, I was glad to get home.

Next day, I lunched in a club on Wall Street. My host, a business man, was in a great hurry, but was profoundly courteous and helpful.

"Well, what do you think of America?" he asked.

I told him that it seemed to be an open-hearted country, and that I had received kindness wherever I went. My host replied by telling me that America was the country where a man could be sacked by his firm on Christmas Eve, where everyone would hurry up the steps of the club while a man died in the street. He said it was a country in which the Jew was still socially segregated, a country that depended on a depressed negro class for its industrial success. It was a country that required of people an empty,

meaningless *bonhomie*. He told me that America was a nation of uneducated people, where, if one had read the editorial in the Christian Science Monitor and quoted it at dinner, one would be counted a brilliant conversationalist. It was a country without modesty. The waiter brought our order, and was angry when my host insisted that if he ordered beef he was going to have beef.

"This" said my host, "is the rudest country on earth".

I decided to go and look at New England. In one town I had two hours to wait for a train, and took a seat on a bench outside the station, watching the people come and go. As I was sitting there a truck driver walked by, then came back again.

"Say bud, what's the matter?" he asked. "Aint you got no pal? Like to come for a ride in my truck. Bud, I can show you a place where the ground's black with rats."

So I went for a ride to the town rubbish dump. The driver chewed tobacco and spat out of the window. We talked about France, and sweated. The weather was tropical that summer.

"Well, what do you think of America?" my new pal asked.

False *bonhomie*? I don't think so. Anyhow, we could find no rats.

Later that week, an old lady sat in her rocking chair and poured tea. She had baked bread specially for the occasion and brought out her exquisite china. She lived in a little white-and-green painted New England house, built all of wood. In front was a veranda looking on to the village street (white dust, the sun intense). And behind her house flowed the river. Her drawing-room surprised me by having no print of Queen Victoria: there was, however, a print of Durham Cathedral. The room was cool and still, with the blinds down, and I could half make out the photo of some Harvard crew, among the dozen other pictures and photographs crowded on the wall. The chair rocked and rocked, and the old lady talked to me in her lovely voice of Harvard and Smith, of her sons and grand-daughters and of how anxious she had been when the river rose the previous winter. Slowly and precisely she explained her family's descent from the Mayflower.

"Well now" she said, "you must tell me what you think of America".

The old lady said that I must go to Boston, so I went to Boston. I sat in the park and waited for the spirit of the Cabots and the Lowells to descend on me. But I found that I was sitting by a children's swimming pool in a slum city, and that the children were Italian, Polish, Czech, and half-caste, and that they all shouted together, splashed together, and that miscellaneous harassed mothers slapped miscellaneous children. I went off to a drugstore and put five cents into a juke box, and listened to Cherry Blossom Pink and Apple Blossom White (or was the cherry blossom white, I could never get it straight all that summer).

On a Sunday afternoon I went to a music festival held in the New England hills. Some miles up a side road was the College, with its concert hall, one of a group of white-painted buildings set on high ground among smooth lawns and elm trees, and beyond was a view of valleys wooded with pine and spruce. A world-famous pianist played, sweating a little in the heat, and the audience clapped, but did not clap too much. In the interval we sat on the lawn, and looked at the delectable scene around us, and it seemed that everyone had been analyzing Beethoven's sonatas from the cradle.

"What do you think of America?" they politely asked me.

I left New England. An old man asked me to dinner, and his negro cook brought in the fried chicken. He told me about the West that he had known as a boy, the West that was wild. He told me about the time (more than fifty years ago), when the coach in which he was travelling was held up by highwaymen, and robbed at gunpoint. He told me about an exciting boyhood in a West long-since tamed, about a frontier where bad men were still bold, and carried a Colt.

"It's all gone now" he said. "Even Texas is tame".

After the fried chicken, there was cream and strawberry shortcake.

Next morning, I read in a newspaper that a teen-age gang had burnt an old tramp alive. And later I discovered that my host, who had described himself as a small-time pressman, was the winner of two Pulitzer Prizes.

A medical student offered to show me round his hospital. He had spent some years in London, and was nostalgic about London buses. London to him was a sort of Athens, full of charming and educated people, kind fat nannies and walks in the park.

"American politics" he said, "are in an undifferentiated schizophrenic state. But don't be put off."

He showed me a hospital throbbing with energy, where students worked from eight in the morning to midnight, where endless conferences strove after integration, where the professor worked in his shirtsleeves and looked like a general directing a battle, a place where scientific medicine was reaching the highest possible level of efficiency.

"Well, what do you think of American medicine?" the student asked.

I went out into the country again, to stay with friends. The daughter of the house took me roller skating, and she grazed most of the skin off one of her knees. Next day she went to the local hospital, and they tore off the bandage and slapped on iodine. The price of this treatment was two dollars.

Reluctantly, after postponing my date of departure, I flew home to England. Sitting next to me on the Stratocruiser was a poet, a thin nervous Englishman afraid of flying, and in particular afraid of the air hostess. I got the question in first.

"What do you think of America?" I asked him.

"Oh," he said, "oh".

We hit an air-pocket, and the poet was poetically sick.

CHAPTER 10

1961: The American Alcohol-related Study Tour¹

It so happens that I recently turned up a file in my office marked ‘US 1961’. Contained therein are 60 sides of handwritten notes on a study tour of North America which I made over a 6-week period in the summer of 1961. Besides the written record, I have many grateful memories of the people who so kindly gave me their time. My travels took me from Florida in the south, up to New England, and on to Toronto, Canada.

The purpose of this chapter is not mere personal reminiscence of the self-indulgent kind. Besides providing a snapshot of a field

¹ Editors’ Note: The text of this chapter is taken from Edwards G. (2008) Visiting America: notes from an alcohol-focused study tour made in 1961. *Addiction* 103: 1939–1947. It is reprinted by permission from Wiley-Blackwell Publishers. Minor edits have been made and several footnotes have been added to make the article more compatible with the book.

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of endeavour at a critical stage of transition from unsupported opinion to a proliferating research base, this chapter is a plea for greater historical consciousness and reflection on the multiple mechanisms, formal and informal, that have helped to shape a now much more mature field. My hope is that what this file has to tell can be seen as relevant to the contemporary world, in that it points to questions around how best today to nurture and develop professional careers in a sector which all too easily can retreat to a culture-bound or nationalistic view of the issues.

The structure of the presentation will be as follows. Certain necessary aspects of background and context will be outlined. The diary notes will then be reproduced. Finally, implications will be considered.

Home base: the Maudsley's involvement with alcohol problems in 1961

In April 1959 I had been appointed to a position at the Maudsley Hospital in London as a Senior House Officer (SHO), a post roughly equivalent to an American residency. The Maudsley offered its junior staff a comprehensive 3-year training in psychiatry. It was and is a National Health Service (NHS) teaching hospital, and with the Bethlem Royal Hospital constitutes 'the joint hospital' which works in close partnership with the university-based Institute of Psychiatry (IOP).

When I joined the Maudsley training rotation my initial attachment was to the clinical unit run by Dr D. L. Davies, the then Dean of the IOP. Davies had consultant responsibility for general psychiatric wards at the Maudsley, but in that setting treated some patients with drinking problems. After comprehensive assessment, a personalized treatment programme was established. These patients were prescribed Antabuse (disulfiram) and introduced to Alcoholics Anonymous (AA). The staff psychiatric social worker on the unit, Mr Edgar Myers, played an important role in a treatment approach which emphasized engagement with the realities

of the patient's life situation. Davies had no interest in any formal school of psychotherapy, and psychoanalytical formulations were firmly off limits. Davies had at that time published a follow-up study of his alcoholic patients (1), but his paper on return to normal drinking was not published until 1963 (2). Working for D. L. Davies was a valuable training experience, and he was supportive of research ideas which his trainees might develop.

The idea of a study tour evolved from discussion with Davies. Aubrey Lewis, the IOP's highly influential professor of psychiatry, was not involved in this initiative and he was in general not particularly interested in alcohol problems. Support was given by the Bethlem Maudsley endowment funds. The visit was made in July and August 1961. I had visited the United States previously in 1955, when still a final-year medical student (3).

Activism versus inertia: the American and UK approaches to alcohol compared

At the time when the study tour took place, the contrast between the contemporary North American and British responses to alcohol problems might, in summary, be characterized as a comparison between American activism and British inertia. That assertion can be substantiated by several different lines of evidence (see Table 10.1). As background, one may note that in the United States the average per capita consumption of alcohol stood at 13.2 litres per person aged over 15 years (4), while the corresponding figure for England and Wales was 6.2 litres (5): the divergence in levels of national activity may, in part, have been reflected in differences in problem levels. In the United States the government response to alcohol problems was being actualized mainly at State level. Jellinek (6) reported that by 1960, 37 of the States, together with the District of Columbia, had enacted legislation promoting some kind of response to alcohol problems. In several jurisdictions an annual appropriation of funds was available for treatment and rehabilitation. Various types of Commission or State

Table 10.1: US and UK responses to alcohol problems in 1961: dimensions of contrast.

<i>Dimension</i>	<i>United States</i>	<i>United Kingdom</i>
National lobbying organization	AA: Alcoholics Anonymous NCA: National Council on Alcoholism	No equivalent
State programmes on alcohol	Widespread	No equivalent
Local councils on alcoholism	Widespread	None
Specialist treatment centres	Developing within state programmes	Warlingham Park the only specialist centre
Private care	Quite extensive	Quite extensive
AA	Well developed	Becoming established
Temperance and church activity	Strong in some regions	Present but not strong
Research activity	An emerging field with Yale Center the catalyst	Weak and with no specialized centres
Annual summer school	Yale summer school influential	None
Learned society	None	Society for the Study of Addiction

programme had been developed but it is difficult to estimate their numbers. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was not established until 1970 (7).

In Britain there was no similar activity at either central or regional government level. The NHS had been established in 1947, but by 1960 the Ministry of Health had not taken any measures to promote treatment of alcoholism. A local NHS initiative led by Dr Max Glatt had, however, supported the development of a specialist treatment centre at Warlingham Park Hospital, Surrey, in 1952 (8). A comprehensive account of developments in British alcohol

policy which took place at around this time has been given by Betsy Thom (9). Besides the government funding for treatment of alcohol problems in the United States and the nascent beginning of an NHS treatment response in the United Kingdom, in both countries there was a layer of specialist private care, but it is difficult to gauge the extensiveness of this latter type of provision in either country.

The US National Council on Alcoholism (NCA) (originally the National Committee for Education on Alcoholism) had been founded in 1944, and by 1961 constituted an energetic lobby campaigning for treatment and public education. It also had local affiliate organizations. Various church organizations were involved on the voluntary front, and the temperance movement was still, in some parts of the United States, politically active. The Women's Christian Temperance Union had 200,000 members, and the American Council on Alcohol Problems provided a coordinating body for Temperance activities (10).

In Britain there was no equivalent to the NCA and there were no local councils on alcoholism. The Salvation Army provided help for homeless drinkers. Alcoholics Anonymous had been founded in America in 1935 and by 1961 was a well-established national organization in that country (11). The history of AA's establishment in the United Kingdom is not well documented, but in the early 1960s there were regular meetings taking place in London and some other cities.

Partly as a result of the AA influence, but also through the activities of the NCA, the disease concept of alcoholism had become widely accepted in the United States at this time (12). Even so, the acceptance was not universal, with some clinicians continuing to equate alcoholics with psychopaths: when published in 1968 the second edition of the Diagnostic and Statistical Manual (DSM-II) of the American Psychiatric Association continued to categorize excessive drinking as a variety of personality disorder (13). There are no data on the penetration of the disease concept in the United Kingdom, but there was wide acceptance of the idea among the leading contemporary medical specialists (14).

In 1961 there was wide US research activity on alcohol, distributed across university departments and academic disciplines (15). There existed, however, only one major specialized alcohol research centre, the Yale Center. That institution was of great importance not only because of its research output, but also as a catalyst and change agent. The Center originated in the 1940s as the Laboratory of Applied Physiology at Yale (16).

In 1962 the Yale Center transferred to Rutgers University. The only other relevant research centre operating at the time in the United States was the Addiction Research Centre, at Lexington, Kentucky. It conducted research of great distinction, but its focus was largely upon illicit drugs rather than alcohol, although important research on alcohol had been published (17). Meanwhile, in 1950, the province of Ontario in Canada had established the Addiction Research Foundation (ARF) in Toronto under David Archibald's leadership. A provincial budget supported service development, education, training and research. The ARF was the only specialist North American institution comparable with Yale in scope and vision (18).

With regard to the parallel situation in the United Kingdom, no specialist alcohol research centres were in existence. Psychology and the social sciences had little or no representation in the British alcohol field, but the Society for the Study of Addiction (SSA) had backed the initiation of some biological research (19). The absence of centres did not imply that there were no individual research contributions. However, a comparison between the scope and quality of the *Quarterly Journal of Studies on Alcohol* (QJSA) and *The British Journal of Addiction* (BJA) confirms that the relevant national research was much more developed in the United States than the United Kingdom. Table 10.2 summarizes the main elements of contrast between the content of those two journals for the year 1961. The four issues of the 1961 volume of QJSA ran to approximately 715 pages, with 49 papers published during that year (20). The corresponding volume of the BJA (21) had two issues running to a total of 139 pages, with 14 papers. With regard to content, the QJSA was predominantly,

but not entirely, the vehicle for publication of multi-disciplinary American data-based reports. In contrast, the *BJA* was a vehicle for opinion pieces and reviews, most of which were British in origin and derived from papers presented at the meetings of the journal's sponsor: the SSA. In general, there was about the *QJSA* the appearance of a forward-looking scientific journal which was concerned with the making of its specialist field, while the impression given by the *BJA* was one of quirkiness. For instance, J. Y. Dent, as *BJA*'s then editor, used a book review as an opportunity to declare that the 'the use of apomorphine by mouth is the most satisfactory ambulatory treatment for alcoholism' (21). A poignant hint as to the contemporary state of British addiction studies is to be found in a front-page listing in *BJA* 1961 (23) of

Table 10.2: The *Quarterly Journal of Studies on Alcohol* (*QJSA*) and the *British Journal of Addiction* (*BJA*) of 1961 compared.

	<i>QJSA (vol. 23)</i>	<i>BJA (vol. 56)</i>
Year of foundation	1940	1884
Editor	Mark Keller	John Yerbury Dent
Number of issues published that year	4 and a supplement	2
Number of articles published	49	14
Number of pages published	715	139
Data-based reports	Many	None
% of authors with PhD	21/49 (43%)	2/14 (14%)
Countries represented among authors	1 Chile, 2 Finland, 1 Sweden, remainder United States	United States 2, Netherlands 1, remainder United Kingdom
Subscription rates	\$6 annual within United States	1 guinea a year for non-members

SSA's 'Recent Past Presidents and ex-officio Members of Council': among the 11 people identified in this list, eight had died and were designated as 'the late'.

There can be no doubt that a young British professional setting out on a North American alcohol study tour in 1961 would be likely to encounter a range of ideas and actors very different from those to be found in their home country.

The diary notes of 1961

These are reproduced below in chronological order with some abbreviation. The sites were selected on the advice of the NCA, and in all instances arrangements were confirmed beforehand through correspondence. The schedule of visits did not represent the totality of the American endeavour of that time.

Lexington Kentucky, Addiction Research Center

Dr. Harris Isbell started by talking to me at length about the pharmacological basis of addiction. Turning to treatment, he went on to say that he did not know of any evidence that current methods were effective with narcotic addiction. At present an addict could go to prison for 10–15 years. He regarded these long sentences as absurd. Dr Isbell believed that information on the natural history of addiction has, until recently, been completely lacking. There was now a follow-up study in progress of addicts treated at Kentucky during the last 25 years. One thing emerged—some addicts do indeed give up the drug and never touch it again, but this outcome did not seem to be related to the treatment received.

Dr. Abraham Wikler was bursting with energy and in a hurry. He was interested in why the addict (narcotic addict or alcohol addict) relapses. He was trying to design a theoretical explanation using conditioning models and experiments to test his theories. He seemed capable of generating one idea each minute. Strange backdrop. There is no escaping the fact that the place is a prison.

University of Kentucky

Dr Robert Strauss talked freely and broadly. He started by saying he really had no idea how education or 'propaganda', as he put it, could be employed to reduce the rate of alcoholism. He would like to attack the idea that drinking was a sign of manliness. He doubted, however, whether putting up the price of liquor would have any beneficial effect. We are in a rut with our sociological research on alcoholism, he said. He also offered a sideways remark that Jellinek's phases were poorly authenticated. Encounter with a thoughtful, clever, questioning man.

Richmond, University of Virginia

Dr Ebbe Curtis Hoff showed me his treatment facilities. He has 12 beds and an attached out-patient set-up. Patients are in hospital for 1-2 weeks. I saw a therapeutic group at work. Several non-alcoholic patients were trying to overcome the 'resistance' of patients with drinking problems whom they did not in the least understand. Dr Hoff also talked to me about his research interests.

Raleigh, North Carolina: State Alcohol Programme

Dr. Norbert Kenny (Executive Director) and Dr. McDonald (Medical Director) explained the State programme. The treatment centre is at Butner, about 30 miles from Raleigh, the capital of the state. This centre is so much in the wild that it is difficult to get staff to work there. Patients were admitted for 28 days. The emphasis was on group therapy, lectures and films. One week was devoted to input from a sociologist, a second was given to a psychologist, a third to a psychiatrist, and a final week was for a social worker. At the end of the 28 days the patients are referred to their local clinics and liaison is not always good. About 400 patients pass through the Butner Center every year. Antabuse and aversion treatment are not used. In addition to Butner, about 1,200 cases are admitted annually to a separate centre in Raleigh, with referral by

the Court. This latter institution appears to offer 28-day confinement with no treatment.

Thinking about what is to be learnt from this visit, I perceive the Butner Center as providing an extreme of an academic course on alcoholism in the name of treatment, but this without any attempt to explore the effectiveness of the input. The state treatment programme does not admit black people.

Then on through the Carolinas with a close view of rural poverty.

Georgia: visit to Dr. Vernelle Fox's clinic in Atlanta

The authorities here had closed the city's swimming pools rather than comply with desegregation.

One of the clinic staff invited me to join in a 3-day course he was running for rehabilitation and probation workers. He addressed us in the Board Room, telling us that 85% of alcoholics benefit from the treatment. I formed the view that he was generally misinformed, prejudiced and humourless. The clinic has in the same building in-patient, day-patient and out-patient facilities. In-patients stay for up to 3 months.

The basis of treatment is group therapy. Staff believed that patients did better the second time around. Dr. Fox said that she would probably exclude 'psychopaths, schizophrenics and obsessives' from in-patient care. The willingness to add moral overtones to the programme was highlighted by five of the 11-group therapists being pastors. A film entitled 'How Long the Night', made by the Methodist Church, showed a pastor as the central figure in the process of alcoholic salvation.

Impressions? As ever the touchstone must be the results got. The information on this point (a paper by Dr. Vernelle Fox) suggests that the results are not very impressive. Also, however good the clinic may be at treating the patients who reach it, the programme falls far short of meeting the needs of the State. The skid row bum is considered as immoral—he has no place in the clinic. I was also told that there is no alcoholic problem among black people and no black patients are admitted to the in-patient programme. Along

with disapproval of the bum is moral approval of materialism. The staff member who lectured in the Board Room gave six reasons for treating alcoholics and five of these were financial.

Florida Alcoholism Programme, Avon Park

Mr. Ernest Shepherd (Administrator) and Dr. Henderson (Psychiatrist) showed me the clinic, which is the headquarters of the State Alcoholism Program. There are 60 beds but no out-patient or day-patient facilities—although there are out-patient facilities in other parts of the State. Patients were admitted for 28 days. Readmissions were discouraged. On admission a full history is taken. The case is then presented at a staff meeting and the psychiatrist dictates a short formulation in which such conclusions are affirmed as ‘passive aggressive, schizoid-type, possibly psychotic’. After assessment the patient starts group therapy. But there is emphasis on the ‘therapeutic community’ with much talk of Maxwell Jones. This centre sees particular value in psychodrama.

National Council on Alcoholism, New York

Mr. Gardner and other staff members talked to me about the work done by the Council. There are about 45 employees who occupy a suite of offices that would do credit to an oil company. The main function of the organization is educational. And it produces a large quantity of literature. Speakers tour the country. Advice is given on the setting up of local Councils. Once such a Council gets going it might ultimately inspire the setting-up of a State programme. Asked whether he had evidence that this vast expenditure in money and effort had in fact brought any results, Mr. Gardner said that although he had no experimental proof that education had had any impact on alcoholism, he felt that his own experience and subjective impression was as powerful evidence as any three research papers. Mr. Gardner discussed the relationship of morality and alcoholism and revealed that he happened to be a clergyman. He believed that if an alcoholic was off drink and then

started to drink again, that was a sin. Indeed, excessive drinking (not addictive) at any time was a sin.

State University Alcohol Clinic, Brooklyn, NY

Dr. Benjamin Kissin, Director, engaging and enthusiastic, described the general functions of the clinic. The striking thing about this clinic was the relative poverty of ideas on treatment, compared to the great energy in basic research. But the treatment load might indeed daunt all but the bravest—they can only offer in-patient treatment to patients who are suffering from alcoholic psychosis of one sort or another. The treatment given to these patients is tranquillizers, and in 10% some sort of psychotherapy. These 10% are regarded as having a good prognosis while the remaining 90% are regarded as ‘untreatable’. Antabuse is not prescribed. The out-patient clinic is attended largely by patients who are seen once and never again. Out-patients are given blind either tranquillizers, antidepressants or placebo but as the return rate is singularly low, results are virtually uninterpretable although they reckon on a 17% ‘success rate’. AA played little part in this centre’s operation.

Dr. M. M. Gross described work in which he is trying to determine why some alcoholics visually hallucinated and others aurally. He believed that hallucination is on the basis of peripheral damage, and he thought that recovery from alcoholic hallucinosis may be recovery from an eighth nerve toxic neuritis.

The Yale Centre

The excitement of visiting the Mecca of American Alcohol Studies. I visited the main building at Hillhouse Avenue, a large shabby mansion which has never been fully converted—there were plaster friezes on the ceiling of the laboratory. From the attic to the cellar, something is going on.

Dr. Seldon Bacon was unable to meet me at the Yale Centre. However, he spent 3 hours with me in the evening. He was

aggressive and talkative. He described the National Council on Alcoholism as a 'crowd of cultists—I've told them so', and he had resigned from the NCA Council. He had also threatened to resign from the Connecticut State Commission. Dr. Bacon said that as a sociologist the fascination of alcoholism lay in the fact that here was a uniquely measurable behaviour—people either drank or they did not drink (odd statement I thought). Asked what could be done to prevent alcoholism, he said that drink and driving was something which might be tackled. Another fruitful target might be adolescent heavy drinking. He said that he was against removing moral pressures against drinking, and he saw this as a danger of 'the disease concept'. The next day I had a meeting with Mr. Mark Keller, editor of the *QJSA*.

Long Island Hospital, Boston

Until about 10 years ago, the island could only be approached by steamer, and when the fog came down it could not be left. The setting is picturesque. The sky is blue, the wind blows, the wild flowers blossom. The hospital is a cluster of large factory-like buildings. Within are 1,200 of Boston's elderly and homeless population.

I talked to a social worker. He was square-built, honest, pragmatic. I could have mistaken him for a truck driver. After a week of drying out, alcoholics are asked if they want to 'go on the program'. If they do, they are transferred onto a special ward. There are about 100 patients in the programme. The ward when I saw it looked like a cattle market with stall pens. Programme patients are lined up each morning and given Antabuse in liquid form. They are then driven off to Boston in a bus for the day's work. For the first week each patient is given \$1 per day pocket money, thereafter the patient contributes \$1.50 a day for his keep. If a patient drinks he is not cast into outer darkness but is removed from the programme ward. I left with the feeling that this programme respected the people that it tried to help.

Boston: Massachusetts Alcoholism Programme

Dr. Blacker explained the programme to me. The remarkable thing about Dr. Blacker was that when I left he gave me 83 pieces of literature.

Boston, Massachusetts General Hospital

Dr. Morris Chafetz emphasized the importance of the initial approach in getting patients into treatment. He then discussed his psychoanalytical views. This was the first full-bloodied, passionate exposition of the view that 'alcoholism is only the symptom' that I had heard. For Dr. Chafetz the patient 'chooses' alcoholism, rather than, for instance, 'choosing' schizophrenia. His very poor results judged by abstinence do not deter him from his beliefs.

The Addiction Research Foundation (ARF), Toronto

I stayed downtown in a sleazy hotel where everyone was drunk. Dr. Armstrong is in charge of the ARF's clinical programme. There is a 12-bedded unit. Patients stay for a few weeks. Dr. Armstrong was not able to define which patients he took into hospital and which he treated as out-patients. Very little good clinical research seemed to be going on here.

Dr. Wolff Schmidt met me and I knew myself immediately to be in the presence of a fine and reflective mind. He described the section of the ARF research programme, which represented a very major effort to understand the public health problem set by alcohol, and he laid out the evidence on the relationship between per capita consumption and the rate of alcoholic problems. No one in the United States had so much as whispered the importance of the supply side. He believed that the rate of alcoholism is related inversely to the cost of alcohol.

I was delighted to find that lunch with E. M. Jellinek had been included in my programme. I was shown up to his office and found a man who looked like the sort of grandfather who would enjoy

playing pranks with his grandchildren. He smiles all the time and laughs often. He took me to the Chez Paree. The food was good. Jellinek told me over lunch that his interest in alcoholism had started many years ago when he was in Sierra Leone as a plant physiologist. The expatriate population there consisted of a large number of alcoholics and a small number of sober individuals who spent their time nursing the alcoholics through their bouts.

Jellinek went on to talk about the integration of research and clinical medicine. So far as he was concerned, the problem was a totally artificial one. I asked him what he thought a volume of *QJSA* would contain in 50 years' time. He believed that the major factor determining the contents of the journal would be whether in the next little while we discover if there is a chemical basis for addiction—'whether there is anything in chemistry'. He said we are not far off knowing whether there is something important in that direction, meanwhile (and if not, *faute du mieux*), our main interests will still be in psychotherapy, Antabuse and aversion. He believed that psychoanalysis would be invaded and remodeled by biological science, a phase of 'awkward transition'. He said that aversion therapy, in one form or another, is much older than we suppose. Roman matrons used to put cockroaches into their husbands' drink. He thought that work on the alcoholic personality had long been 'a public scandal' but was now occasionally of better quality. He himself had been analysed and had at the beginning of his career published some analytical writing.

He commented on the English approach to alcoholism, that that country liked to think that alcoholism is un-English, and it is simply not something which Englishmen contract. When he sent a WHO [World Health Organization] invitation to the Ministry of Health in London, asking them to send people to an alcoholism seminar, there was no reply. When the invitation was reissued, he was told that no one was interested.

When we got back to the office, Jellinek enlarged upon his current interest—the use of alcohol (not simply alcoholism) in modern American literature. He said that he feels that the picture given in popular literature is a very accurate one, and that the effort to

reconstruct drinking patterns by reading the literature of past societies may have validity. 'I need a drink' occurs two or three times in most American novels but is almost unheard of in European novels. 'Ask an American whether he likes the taste of drink and he'll think you are mad. He drinks for what it does to him.'

It was difficult to end this meeting. I went back to my seedy hotel, and with memory fresh made the fullest note possible.

The study tour: benefits derived

Taken as a historical record, these diary notes are, of course, limited in that they come from only one person visiting a restricted range of treatment and research centres. The picture thus derived does, however, seem to catch the North American scene at a moment of transition. The United States was striving towards definition of a post-prohibition response to alcohol and the snapshot shows the many tensions and residual contradictions. Moralism was widely latent, although alcoholism was acquiring a disease status. Treatment was becoming increasingly available, but with gross random divergences between different centres. Prevention was limited to education. The NCA and State programmes spoke to much activism, but one has Bacon's stigmatization of 'cultists' ringing in the ears. Whatever the contradictions, there is here a sense of ferment, energy and a field being made.

Seen in retrospect, the benefits from this tour were significant in several respects. The timing of this trip was personally propitious in that, in 1963, opportunities arose for the establishment of an alcohol research programme at the IOP (24). Although the encounters were essentially unbalanced as meetings between established North American experts and a British postgraduate in training, some of these contacts evolved into collaboration and valued friendships. Milton Gross shared crucially in the development of ideas on alcohol dependence (25): there was to be later collaboration with Wolf Schmidt (26) and with Mark Keller (27). The impacts that are likely to have come from personal meetings at an early career stage with professionals of the highest calibre are difficult to quantify, but to have met them face to face undoubtedly

enriched an understanding of the breadth of the field, its horizons and its opportunities, and fired motivation.

Perhaps rather surprisingly, the study tour was beneficial to the visitor in a negative as well as a positive respect. Although the treatment of drinking problems in the United States had at the time much more momentum than in the United Kingdom, the American scene was remarkable for the diversity of opinions held by the protagonists as relating to the appropriate settings, duration and content of treatment programmes. Confident positions were being taken without any kind of persuasive research underpinning, and that conclusion directly invited an interest in development of a controlled trial on in-patient versus out-patient care (28) and later research comparing the effects of treatment and advice at the Maudsley base (29). There was a similarly fruitful negative encounter with US ideas on prevention of drinking problems, with the pervading American belief in the effectiveness of alcohol education again underpinned by no evidence: the contact with the ARF and Wolf Schimdt was, however, profoundly influential in stimulating a research-based perspective on alcohol policy (30). A further impact on research thinking was that the American experts met on this tour were not well able to specify what they meant by 'alcoholism'. The idea of alcoholism as a disease appeared at the time to have the force of doctrine but with little attempt to operationalize or validate the concept—so here was the invitation to develop ideas on the alcohol dependence syndrome and explore its validity (31). Finally, under the research heading, the visit to Long Island Hospital and the evident humanity of that project in contrast to the general disdain for the 'the bum' inspired research at the IOP (32) and related community and service development (33).

Academic visitations and their future

An account of this one study tour made almost 50 years ago, and of the benefits which accrued, may perhaps serve as some sort of catalyst for questions around how we are to encourage and enable similar kinds of travel today. Such visits can contribute to career

development and academic community-building in a very different and ever-expanding research world. Alcohol studies here pose questions not greatly dissimilar from those attaching to many other sectors of academic endeavour; but it might be argued that views on substance misuse tend rather easily to have their agendas set by national and political imperatives, and by historically determined and culture-bound modes of thinking. For those reasons the cultivation in this particular field of wider awareness, at an early career stage, is likely to be especially beneficial.

There will always be some basic logistic issues to be met, such as who to send at what stage of career and with what itinerary. In the instance discussed in this paper, the visit was by a UK student to North America and for many students, whatever their country of origin, that will still be a favoured direction of travel. There is, however, a need to establish better two-way contacts between Anglo Saxon and other scientific communities and the needs of young professionals from the developing world must be addressed.

The value of the 1961 tour lay partly in the contrasting introduction it gave to a sector of elite science and to a world of activism which cared little about that science. That was a fortunate but chance feature of the itinerary. The extent to which that gap has since closed remains an open question. There will often be value in an experience sufficiently varied to provide some insight into the broad nature of the multiple dimensions of the national response—seeing only laboratories, only clinics, only bureaucrats, is seldom enough. It is the country and its culture which are at best the units of study.

This is a field which is not sufficiently reflective, both as to its history and its present mode of operation, and it gives little attention to fundamental questions about how we train and induct the next generation of scientists. It has not been possible to identify any research that has surveyed the travel experience of young professionals in this field or which has sought qualitatively to assess the benefits. Those of us who have benefited personally from such ventures are likely to argue that no one should proceed to a substantive appointment in this field without the stimulation

and self-questioning which comes from experiencing other clinical and academic cultures besides one's own. Books and journals read, e-mails exchanged, a conference attended, hearing a visiting lecturer speak: all those experiences are useful elements towards the building of a career and what is on offer today greatly exceeds in scope anything imaginable in 1961. At best, such travel at an early stage in a career should challenge, inspire and perhaps also confuse and invite doubt. That experience is likely to be both emotional and cognitive. There are still inspirations and insights of a quite special kind to be gained from personal contacts, and a view of the world from other windows than one's own.

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CHAPTER 11

1966: Peru, Chile, and Subsequent Work with the World Health Organization

On an afternoon early in 1966, I walked along to the porter's lodge at the Maudsley to pick up my post. I was handed an envelope with a lot of pretty stamps on it, and opened it to find an invitation to give a paper at a conference which was to be held in Santiago, Chile, to honour the memory of E M Jellinek. All expenses would be paid. This invitation derived from a Chilean hepatologist who had recently been passing through London and had called by to talk to me about the work of our research group.

This was an invitation quite to bowl one over and not at all the usually expected fruits of a Maudsley afternoon. I talked to D L Davies who fixed up sideways lecturing invitations for me in Peru and Venezuela. This was dazzling stuff for a young researcher who had previously been excited by an invitation to speak at a conference in Torquay.¹

¹ A seaside resort town on the English Channel in Devon, south west England. It is known for beaches and Victorian architecture.

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So to Lima where I was introduced to an ancient Spanish aristocracy and played chess with the beautiful young daughter of the house: when I had tactfully let her win the delighted mother took off an Inca necklace and gave it to her daughter as a reward. Life at this juncture had become filmic rather than real. That impression was enhanced by the long flight down the spine of the Andes which took me to Santiago. There I stayed in a dark and eminently Victorian hotel, met Kettil Bruun for the first time ever, went with Mark Keller to a night club, was interviewed for the radio by the delightful Manuela Gumucio who took me home to meet her father who was a Senator, made a lasting friendship with Jorge Mardones, spent a weekend at Valparaíso and saw the Southern Cross while listening to flutes played by young people in love on the seashore. All that, and I gave a paper on our controlled trial of inpatient versus outpatient treatment of people with drinking problems (1).

At this meeting I chanced upon Joy Moser who was attending as the sole representative of the World Health Organization (WHO). Joy was English and had originally been appointed to a bibliographic job at WHO, Geneva before moving on to part-time responsibility for WHO's work on alcohol. I was immediately aware of her charm, toughness, and professional capacity. When we flew back up the Andes she was in Club Class and I myself was travelling Tourist, but we had a conversation by instalments at each stopover. That Joy should have identified me as someone potentially useful to her work speaks to the underdevelopment of the field at that time. I had no experience of international work but was quickly recruited by her to help WHO prepare its first ever integrated programme on alcohol activities. Before long I had been asked by Dale Cameron, her opposite number on the drugs side, to do the same for drugs. Who seriously could doubt that life is often made by accident?

So from 1966 onwards I was heavily involved in work for the WHO headquarters' office in Geneva and at the European office in Copenhagen. I was involved in a variety of projects quite beyond any easy listing and there were papers to be drafted, meetings to

be attended and the world to be travelled. Sue and I spent our honeymoon courtesy of WHO, Copenhagen. Financial rewards were small but savings from per diem allowances were converted into purchase of Hockney prints.²

WHO was a learning experience woven around tutorials from the people with whom I was working. Joy Moser was someone profoundly sensitive to other cultures. She herself was possessed of total integrity and apt to be vastly critical of those colleagues whom she regarded as betraying her ideals. She was married to Max Moser, an archetypal Swiss lawyer and I would often stay in their flat in the Rue de Vermont or spend weekends at their chalet at Cote Malherbe. Dale Cameron was in comparison a rather dull-minded American medical bureaucrat whose idea of getting to know Europe was to drive across the continent in his Mercedes with the windows closed eating chicken legs. When Dale retired, his position was taken by Arni Arif, an Iraqi doctor of wily disposition whose company I much enjoyed.

Upstairs in a grand office was Tom Lambo, Deputy Director of WHO and someone whom I knew through other networks. I would often make calls on him when in Geneva. Our meetings tended to be strangely ceremonial and he had a habit of addressing me as "Your Excellency" without obvious mockery. To describe the totality of the work for WHO over something like a thirty year period would be tedious. I will attempt only to sketch just some of its variety. After helping Joy with the design of her alcohol programme I took responsibility for helping organise a high-level travelling seminar for health workers from different countries: we spent a week in Poland, in Holland, and in the UK, and tried to develop with our students a sensitivity to what we called the "National Response", the country's overall way of dealing with alcohol. With Joy I then set up the Community Response Project which explored how different actors and agencies respond

² David Hockney was an English painter, printmaker, and photographer who was an important contributor to the pop art movement during the 1960s.

within the community to alcohol problems. That project established research bases in Zambia, Mexico and in Scotland. I helped Arni produce a book on cultural responses to drug problems (2). I was a member of various committees and Expert Committees, and on one occasion addressed an international meeting of Health Ministers. In Copenhagen I helped design the way in which data on drug misuse would be gathered from member states and later assisted developing responses to the HIV/AIDS epidemic among drug users.

What was rewarding about this WHO experience? Working with Joy and Arni was happiness in its own right and professional responsibilities were intertwined with much friendship and affection. Also intensely rewarding was the learning from these and other WHO hands how to see into other cultures and countries and respect them. And in the interstices of all else was the reward of the occasional feeling that one was perhaps in a small way contributing to the betterment of the world.

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CHAPTER 12

1967: Diary of a Drug-focused Tour¹

In 1965 the publication of the Second Brain Report (1) marked official acknowledgement that Britain was experiencing a steep escalation in the number of people addicted to dangerous drugs, as notified to the Home Office. In 1955 the notifications stood at 355, with 57 of these cases having heroin as the main identified drug. By 1965 the total was 927, with 521 cases involving the use of heroin (2). The absolute numbers were still quite small, but there was a sense of threat and anxiety as to what might happen next.

The lead department responsible for responding to this situation was the Ministry of Health. Addiction in the United Kingdom had, since the 1926 report of the Rolleston Committee (3), been defined as predominantly a health issue rather than a criminal

¹ Editor's footnote: The text of this chapter is taken from: Edwards G. (2020) Seeing America—diary of a drug-focused study tour made in 1967. *Addiction* 105(6):984–90. It is reprinted by permission from Wiley-Blackwell Publishers. Minor edits have been introduced in the form of explanatory footnotes.

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issue, and doctors were allowed to prescribe injectable opiates on a maintenance basis to their addict patients. Following Brain Two, the new response was still rooted in the Rolleston tradition. Clinics would be opened to allow designated National Health Service doctors to prescribe injectable opiates for maintenance (4).

At the same time the Ministry declared an interest in funding an addiction research centre. Unsurprisingly, in 1965 there was no relevant research institute in the United Kingdom which specialized in this field of study—until then there had been no problem of a magnitude to justify such investment. In 1967 the Institute of Psychiatry (IOP: a postgraduate school of the University of London) was funded by the Ministry to create such a group, the Addiction Research Unit (ARU). Planning was immediately got under way. This unit was to be grafted onto an existing alcohol research team. Four new research positions were created and purpose-built accommodation provided at 101 Denmark Hill, on the Institute campus.

The Americans were interested (5–8) in the medically orientated British approach to the heroin problem, the so-called ‘British system’. In late 1966 Dr Stanley Yolles, the Director of the US National Institute of Mental Health (NIMH),² made a fact-finding visit to London. He held discussions at the IOP with Sir Denis Hill, the then Professor of Psychiatry, and with Griffith Edwards, who was Director designate for the soon-to-be-established research centre. Yolles made a generous offer to fund travel which would enable Edwards to visit drug treatment and research centres in America.

That invitation was accepted with alacrity. The United States had a very different history and pattern of response to drug problems to the United Kingdom. The problem in the United States was much bigger, was widespread rather than concentrated in just one city (London), as in the United Kingdom, and was underpinned by a criminal black market (9). In the United States the problem was

² The US National Institute of Mental Health (NIMH) was established in 1949 in Bethesda, Maryland, near Washington, DC as part of the larger array of research institutes called the National Institutes of Health.

associated with ethnic minority status (10, 11), and often embedded in inner-city poverty (12). Treatment for addicts was available in the United States, but at the same time the criminal law was a heavy presence, and prescription of heroin was entirely prohibited.

With full awareness of the contrast between the two countries there was, none the less, no doubt that a visit to America was likely to be immensely beneficial for a researcher who was charged with developing an investigative programme for the ARU. The visit to America was made in March–May 1967. The account given below derives from extensive contemporaneous diary notes which were dictated onto a tape recorder at the end of each working day, and later typed up in my office. Extracts reproduced in this paper represent both verbatim and edited material, and have been selected to give a balanced representation of what was seen at this time of America's engagement with drugs. The original typescript of these diary notes has been deposited in the Institute of Psychiatry's archives. A report has been published previously of an alcohol-focused American study tour made in 1961 (13).

The prime intention of this paper is to put into the public domain an eye-witness account of the American response to the drug problem at a fairly crucial period. Much was going on in the background in relation to multiple cultural and political developments, but this paper will not attempt to map that context. Neither will much discussion be directed at analysis of the later impact of this travel experience on developments at the home base. In sum, the intention is to present the diary notes as observations speaking for themselves, but their interpretation will inevitably need contextual awareness of various kinds.

The diary

23–25 March 1967, Bethesda, Maryland

Called on Dr Stanley Yolles. The pressure from NIMH at this time was towards funding of drug treatment through community mental health centres, and this formula has a doctrinal flavour. Time then spent with a number of researchers, including Dr. Jack

Mendelson, Director of the National Centre for Prevention and Control of Alcoholism. Talked about the research horizons with a young staff member, Dr. Roger Meyer. A discussion with Dr. Ira Cisin, whose drinking survey work I already knew well. He is now planning national drug surveys. Impressive methodological expertise, and his current drug interview schedule has gone through eight pilot phases so far. But when I pressed him on questions around possible alternative research designs to mega surveys (e.g. small group qualitative work), he said 'we do the work for which we can get funding'.

27 March–3 April, Lexington Hospital, Kentucky

The size and complexity of what goes on in this place, so many strands to the operation and so much accumulated professional experience, all this is daunting. There are some hundreds of addict patients in residence and there are 500 staff (shortly before my visit the total number of residents had stood at 2,000 but Civil Commitment had altered the responsibilities of this centre). I will not do more here than record certain main impressions.

The first theme I will abstract derives from the repeated, throwaway, end-of-meeting kind of observation, offered by many different staff members of varying rank and professional background—'don't do drug treatment our way'. They criticize the mind-set imposed by the legal structure which makes drug addiction into a criminal offence, rather than a mental health issue. Shutting up addicts in this institution for many months at a time and often with little in the way of subsequent follow-up or community care was a therapeutic formula which nearly everyone concerned viewed as doomed to failure.

Secondly, I believe that there is a nightmarish quality to the use of inmates for experimental purposes. One experimenter referred to this category of patients as 'old dopeys', and said that whatever the future of the Lexington operation there would be a need to obtain a 'stock' of such human subjects. A free drug experience,

better ward conditions, remission of sentence, that together constituted quite an inducement.

Third theme, high science. Pharmacologists, psychologists, psychiatrists, social scientists of great distinction, gave me their time and I packed my notebook. Two sessions with Dr. William Martin, discussing heroin versus methadone as a maintenance drug, were particularly rewarding. He described methadone as 'an easy, superficial way of dealing with addiction,' but identified numerous arguments against injected heroin as a maintenance drug.

4-7 April, Fort Worth Hospital, Texas

This hospital is operationally very similar to the treatment component of Lexington. It does not have so developed a research base. Tensions were evident between security and treatment staff, and the same fundamental confusion reigned as to whether this was a penal or a therapeutic facility. The general assumption shared by staff seemed to be that addicts from a deprived working-class background were, to a man or woman, 'sociopaths'. Discussion with Dr. J.F. Maddox, Deputy Medical Director, who believed that for this type of subject a minimum of 3 years compulsory detention was a necessary preliminary. Another staff member suggested that inmates should only receive psychotherapy if they paid for it themselves.

10-11 April, Southmore House, Houston, Texas

Mr. M. Carrick, Executive Director, headed this demonstration, community-orientated project funded by NIMH. At any one time it had about 12 addicts in residence, and contact with about 30 others living nearby. The house had opened in 1964 and since then there had been six changes in House Parents. Residents had absolutely no responsibility for the running of the house, group attendance was poor, drug taking was rife and the staff and patient ethics had little in common. Meanwhile, a sociologist was administering an attitude change questionnaire.

11–12 April, San Antonio Field Unit, Texas

This was an NIMH project which worked in collaboration with Fort Worth, and theoretically offered both pre-care and post-care. Most patients are Mexicans, and the background to the local drug problem is poverty and discrimination. Interview with Mr. Samuel Brito, a Mexican social worker who spoke with contempt of the dominant Anglo culture. The project, he said, did not have enough tangible services to offer its clients, and was failing. Welfare meant the handing-out of damaged tinned goods, or otherwise ‘stealing was welfare’. Rather surprisingly, two Narcotics Agents then showed up. Mr. Joseph Arpaio,³ who was a Federal Agent, told me that the Federal Bureau of Narcotics was ‘winning the battle’, and he was ‘all against the British system . . . I am a firm believer that if someone sells narcotics they should not be given much consideration’. Lieutenant Charles Doerre was a city Narcotics Agent. He objected to a recent change in the law which had deprived him of the right to arrest addicts simply for drug use. He believed in the effectiveness of harsh sentences and spoke with relish of an Ohio law which allowed a 20-year sentence for a first drug offence. Met briefly with a Catholic Priest, Father Dermot Bosaen, who said of the drug problem: ‘I’d go hog wild on prevention’. He asserted that one-quarter of Texans were living in poverty and this was the root cause of most of the addiction.

13 April, Synanon at Santa Monica, California

The immediate impression was of an organization pulsating with activity. Currently there are 700 residents living in six houses. Although the majority are former addicts, Synanon is willing to

³ Joseph Arpaio (b., 1932), a former law enforcement officer and politician, went on to become a controversial proponent of the US “War on Drugs” and was over the course of his career accused of numerous types of police misconduct and civil rights violations. In 2019 he was pardoned by then President Donald J. Trump.

admit non-addicts, and sees the fundamental mission as treatment of an underlying personality disorder rather than of addiction *per se*. The senior staff people to whom I talked wore suits, and were self-confident and highly assertive. They expressed their paranoia openly towards researchers, the medical profession and the outside world in general. Any request for outcome data provoked rage. Along with the institutional paranoia went a worship of material success. Enormous sums have been raised by public appeal; a card index with the names of 10,000 donors was shown to me; they are buying rather than renting property. They run five petrol stations and grossed an income of \$1 million last year from various retail projects. They had 40 automobiles in their car pool and hoped shortly to acquire an aeroplane. Recreations available to residents, that were listed on a notice-board, included horse riding, deep sea fishing and skiing.

14–15 April, California Rehabilitation Centre, Corona

This project represents an attempt to deal with heroin misuse commensurate with the dimensions of the State's drug problem. There are said to be 18,000 heroin addicts distributed across California's 18 million population. The centre has about 2,000 residents at any one time, with an additional 1,700 on parole.

About 6% of the residents are here on a voluntary basis, while the rest are on court orders termed 'Civil Commitment'. An addict who is before the court on certain categories of criminal charge may be certified as an addict by two doctors and then committed by a judge to a treatment programme for 7 years, with at least the first 6 months spent in a closed institution. The admission process is biased towards admitting addicts who are on felony charges. People in that category may invent addiction in order to escape a long prison term, but someone who is charged with a misdemeanour will probably opt for a short prison sentence rather than a lengthy Civil Commitment. A key feature of the process is that, on release, patients will be tested with naloxone to detect whether they have relapsed: relapse will trigger compulsory re-admission.

Prison or hospital? The addicts were housed in the 60-bed wards of a vast former naval hospital. The director is a prison service official who is not medically qualified, and he told me that psychiatrists do not know how to treat addicts. More senior staff tended to be bullish, while junior staff spoke of poor staff selection, poor training and petty administrative interference. Although there is investment in follow-up research it is difficult to see how, in the absence of controls, the research will be interpretable. A high double fence surrounds the facility and armed guards patrol the perimeter.

17 April, US Naval Hospital, Oakland, California

Visited a project which is the unlikely brainchild of Dr. Mitchell S. Rosenthal, a young navy doctor engaged in his 2-year military service. He has persuaded the Navy to allow him to set up a 20-patient residential therapeutic community for treatment of personality disorders or substance abuse. The authorities have been worried for some time about the manpower loss caused by these kinds of problem.

The intensity of the patients' commitment to the programme was palpable, with otherwise lost and deprived young men talking about 'growing up'. I sat in on a 2-hour group, termed a 'game'. The format involved verbal attacks on a sequence of group members with the language employed being of an intensely abusive variety. The emphasis was on achieving tangible change in behaviour. Now and then the process degenerated into noisy bullying, but for the most part the impact seemed to be positive, often resulting in evident catharsis. The influence of Synanon on this programme was very evident.

18 April, Department of Pharmacology, University of California Medical Center, San Francisco

Conversation with Dr. E.L. Way. He commented on the British belief that heroin constituted a potential maintenance drug. He

attacked this idea root and branch, giving objective reasons for this rejection. Unless heroin addicts were super-loaded with this relatively short-acting drug, he believed that they would 'always be asking for more'.

18 April, a psychiatrist at Palo Alto, California

This private psychiatrist seemed to represent the wilder edge of Californian thinking. He was using lysergic acid diethylamide (LSD) in the treatment of alcoholism. He told me that alcoholism was 'not a disease but a search' and psychiatrists generally did more harm than good in the treatment of this condition. The aim of his treatment was to produce 'an overwhelming mystical experience', and sobriety was not essential to recovery. When I sought more detail on his treatment methods he angrily refused to continue the conversation, and cut me off with a remark that 'it is feelings not facts that matter'. He told me that he had himself taken LSD 70 times in a quest for personal insight, but had now given that up for parachute jumping. He drove a Lotus Elan.

24 April, Billings Hospital, Chicago, Illinois

I met with Dr. Jerome H. Jaffe: NIMH had described him to me as 'the most brilliant brain in the business'. I found myself in the company of someone who was capable of thinking of addiction treatment services as a comprehensive population-level issue—at this juncture he was only just getting his funding into place, so we were talking about intentions rather than about services that were up and running. He had a rigorous view of the need to assess objectively the effectiveness of different treatment modalities, but was at the same time fully aware of the difficulties of mounting controlled trials in this kind of terrain. He insisted that no single treatment approach will be sufficient to meet the needs of all patients—he saw, for instance, the need to expand methadone maintenance but was at the same time willing to invest in

a Therapeutic Community. He recognized what medicine and psychiatry could offer but demonstrated a willingness to also collaborate with lay organizations. This was someone who was likely to use data as a planning tool rather than as mere ornament. He told me that his 2-year budget stood at \$2,359,300.

27 April, Cambridge, Massachusetts

I called on Dr. George Vaillant at his home and we sat out on a lawn under cedar trees. His conversation was coloured by wit and subtle intelligence. His emphasis was on the need to understand dynamically the addict's life course. Prior to his highly productive Lexington follow-up research he had been looking at schizophrenia within a longitudinal frame. His approach derived from a psychoanalytical position, but was devoid of cant and rooted in empiricism. He believed that parole was more likely to turn the addict's life course around than any amount of psychotherapy.

28 April, Bernstein Institute, New York

Meeting with Dr. Marie Nyswander. I was in the presence of an enthusiastic, optimistic therapist whose work was guided by a model of understanding very different to that of the usual person who runs an addiction programme in the United States. She made frequent comparisons between diabetes and addiction, with methadone the insulin for addiction. Addiction was for her a physical disease, and addicts were not nearly such disturbed people as others suggested routinely: the seeming personality disorder was likely to be consequence, not cause, of the addiction. Four hundred and twenty heroin addicts were attending this centre and receiving a daily oral dose of 100 mg methadone. There was no psychotherapy nor social interventions on offer. A comprehensive and continuously updated database was in operation, but with no attempt to establish the validity of the outcome data that were being recorded. I talked to some patients who were firm believers

in the worth of methadone maintenance—without rendering them intoxicated, it ‘took away the big fight’.

*28 April, Rockefeller Hospital, New York, meeting
with Dr Vincent Dole*

He asserted that for many addicts methadone offered ‘the first chance to regain human dignity’. I had the impression of someone who was motivated equally by compassion as by a desire for scientific understanding. It would be easy to dismiss his approach as no more than the medical model incarnate and simplistic—he wanted addicts to redefine themselves as ‘patients rather than addicts’ and wished to see them ‘surrender to the doctor’. He expected to show that addiction derived from ‘an identifiable metabolic defect’. Probe more deeply and more subtle thinking becomes apparent, and an awareness of the social and psychological components to the cause and cure of addiction.

As for methadone maintenance, Dole said ‘there was no need for further research on efficacy’. Effectiveness of treatment had now been proved and the need was to find ways of expanding the programme to meet demand. His own treatment facility currently had a 1.5-year waiting-list and was ‘besieged’.

30 April–1 May, New York

Various treatment centres in New York which shared the common features of expense, a large number of grandiose claims, contempt for other people’s efforts, and lack of any connection to the realities of the surrounding streets.

*2 May, West 84th Street, meeting
with Father James Gusweller*

He breathed reality as a priest who for the last 10 years had been dealing with the social problems of his parish. He told me that

the racial divides set 'terrible problems' for this city, with no evidence of any substantial improvement. The white people retreated into their own communities, took their children out of the decaying public schools, attended their own churches and did not much care about the deprivation which surrounded them. A bright child from an African American background would have little chance of a good education, and would grow up in 'a situation of total frustration'. High rates of crime and drug use were the consequence, and he saw addiction as 'no more than a symptom of very deep-seated ills'. He said that about 20% of Americans did not believe that they belonged to their country.

3 May, New York, Office of the Narcotics Co-ordinator

Meeting with the Director, Dr. Efren Raimirez. He had established a considerable reputation in Puerto Rico before coming to New York. He was a strong believer in the Therapeutic Community approach as the dominantly appropriate model for the treatment of addiction, and he asserted that methadone maintenance was only likely ever to be appropriate for about 10% of the total case-load. The physical aspects of addiction were, he said, 'irrelevant' to the understanding of the condition. As for how Britain should now deal with its drug problem, his advice was simple: that country should replicate what he was doing in New York and invest heavily in Therapeutic Communities. This was said seemingly with no awareness of the different cultural and demographic profiles of addicts in New York and London.

What the experience gave

By any reckoning, this visit provided an extraordinarily rich and challenging experience. I had travelled the country coast to coast and seen contemporary America not only in terms of its response to drugs, but also in some ways more deeply in terms of its innovation, its energy and its capacity to embrace conflicting values.

Not only had there been the privilege of meetings with important scientists, but I had sat around with narcotic agents, social workers and clergymen, and had heard that crime was welfare. I had attended the opera and heard the Grateful Dead play, and enjoyed the hospitality of people's homes. That was, in sum, an experience to invite reflection rather than immediate and facile conclusions. Working out what the totality of that experience gave was, in reality, a process that continued over many years.

In the concluding section of this paper no attempt will be made at detailed, point-by-point analysis of the impact of this visit on the development of the ARU's research programme. The aim is not to provide an institutional history of that kind, and much of the unit's early drug research was collated in an edited volume (14).

The need to think of drug policies strategically and in terms of 'national response'

Despite the energy and variety of the projects seen in America, nowhere was there at the time a sense of strategic central national planning. One should, of course, be aware of the traditional American need to find a balance between State and Federal policies, and State policies on addiction were in 1967 beginning to be developed, notably in California, New York and Illinois. Under Jerome Jaffe's leadership and with the establishment of the Special Action Office on Drug Abuse Prevention (SAODAP) a strategic national policy of a kind which, in 1967, had been lacking, was put into place in the early 1970s (15). However, it was to be more than another 20 years before a similar English national plan emerged (16). Jerome Jaffe's unique effort to devise a state-wide system in Illinois was of exceptional interest.

In collaboration with the World Health Organization (WHO) shortly after this visit, an attempt was made to develop the idea of 'national response' as a multi-factorial, dynamic, interactive system. An international meeting was convened in London to assist in the development of this concept. Slightly later, Edwards worked

with Jaffe on the further elaboration of this idea, and a position paper was prepared for a WHO Expert Committee, when Jaffe had been appointed as first director of SAODAP (17, 18).

At the time of this visit, America seemed to be in the grip of sharply conflicted models of understanding as to the nature and cure of addiction. There were people who believed that addiction was a personality defect, others who saw it as a metabolic disorder, and still others who identified it as no more than a symptom of poverty and deprivation. There was ambivalence as to whether punishment or treatment were the more essential components of policy. This situation seemed to point to the need for Britain to clarify its own answers to these dilemmas in changing circumstances—a need to articulate and debate the underlying assumptions rather than merely reach for this or that policy response (19). With such a perspective, drug policy itself and its determinants became an important focus for study (20).

The need for historical awareness

Throughout this trip it was unusual to find any informant eager to bring into the discussion an awareness of the historical development of America's drug problems or the responses to those problems. There was no sense, therefore, of history being able to inform contemporary policy choices or moderate contemporaneous passions. Of course, this neglect was repaired before long, with distinguished American historical work evolving (21, 22). A line of relevant British historical research was also developed shortly (23), with funding for a British scholar coming initially from the US-based Drug Abuse Foundation.

The heroin prescribing question

The work of Dole and Nyswander had established the effectiveness of oral methadone as a maintenance drug, but back in Britain the newly opened drug treatment clinics concentrated their efforts

on the prescribing of injectable heroin (24). That choice had little pharmacological merit, but in retrospect was not at that time an irrational response to a relatively small national drug problem not underpinned by an organized black market. It was only after some years of perseverance with the traditional 'British system', and in changed circumstances with the evolution of a criminal black market and of person-to-person transmission, that oral methadone became the drug of choice for the British clinics (25).

The streets outside

Despite the far greater development of the American research response to the drug problem than anything seen in Britain at the time, there appeared to be little willingness to explore the significance of social deprivation in the genesis of the drug problem—and that despite the witness of Mr. Brito in San Antonio and Father Guswell in New York. Chein's work showed that such research was feasible (12). The roots of this research neglect seemed to be political: unwillingness to confront the reality of social deprivation in America. That was too uncomfortable, and research was more on clinic samples, the Lexington population and the abstractions of national surveys than on communities. The lesson, surely, was that a comprehensive national research response to drugs must have a clinical component, but there is also much to research outside the clinic. At around the time of this visit, Lyndon Johnson launched the 'war on poverty', but it is doubtful whether this initiative could have reached the structural causes of America's then contemporary drug problem.

The personal dimension

Certain limitations to this travel experience must be admitted. Although the places visited and people talked to were extensive and varied, they were inevitably selective, and it is likely that a British visitor coming in from the outside would at times have

clumsily misunderstood or misrepresented the American scene. That said, beyond the dimensions identified above, there was one further, lasting, and pervasively positive outcome from NIMH's generous funding of that 1967 opportunity to see America. This was the establishment of the continuing professional contacts and the lasting friendships made.

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CHAPTER 13

1970: The Streets of Calcutta¹

The crowd presses. Three boys seated on the ground beat drums. A turbaned man blows his wailing pipe. A young woman dances a writhing dance—she spreads a white hood behind her head. Slowly the cobra rises from its basket, looks round, seems almost bored. A metal bowl is thrust angrily into the crowd by the piping man and he reaches it out accusingly into the back row, still playing his pipe which he holds in his left hand. A few coins are thrown into the bowl. An assistant carries round for exhibit a small animal which looks like a hedgehog. People touch it. The woman smiles, the boys smile, the man is angry, the crowd watches silently, the piping wails on against the bass of the drumming. The cobra looks at us all with distaste. Calcutta at midday, the sun burning down.

¹ Editor's Note: This essay was published in *New Society* (7 May 1970, pp. 771–4), under the title “The Streets of Calcutta.” *New Society* was a weekly magazine of social inquiry and cultural comment that operated in the United Kingdom from 1962 to 1988. Reprinted by permission, courtesy of *The New Statesman*.

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Reluctantly, we walk on.

The Sikh taxi driver makes his old car go like a runaway horse, sounding the klaxon for pure joy, shouting imprecations, bent forward. The streets are, as ever, crowded beyond belief. Cows pay no heed to the traffic and pedestrians scant heed. People cling to the crowded trams. Beggars squat or lie on the pavements. The Sikh does not understand us very well and we get out at what is almost certainly the wrong place. We enter a shaded convent.

"Mother Teresa is here?"

"Good Mother is here."

"She expects us."

"She is not here."

Mystification.

"Where is she?"

"That way, that way and then that way."

The old doorkeeper makes some incomprehensible sinuous movements with his hands. We walk on down the hot road. A rickshaw trots beside us, the riskshaw boy chanting a song which rises and falls but has neither obvious end nor beginning.

"You walk straight along this road, and opposite a big church you will find Mother Teresa."

A man is laid out in the sun dying perhaps. A group of bystanders has gathered to watch. The road is lined by endless shabby little shops. Everyone seems to want to sell, no one seems to want to buy. The pavements are thronged, the city shimmers with life.

At last we come to a door in a high wall. Thin patient women are clustered outside. We pull a cord, a bell rings, and we are let in. We enter a courtyard where more women wait and where great pots of vegetables are being prepared for an evening meal.

"Mother Teresa is not here."

"Where is she?"

"Follow."

We go out again, the circle of silent waiting women fall back to give us passage. Down the road, up an alley, and at last we find 54a Lower Circular Road. We wait in a cool shadowy room, with sun coming in through the open door. A bible, and ashtray and one

small pious ornament on the heavy table. There is the sound of sawing, the sound of chanting and the smell of fresh paint.

Wall charts give bare details to the work. The Society of the Missionaries of Charity was founded in 1950. Its work is to be apostolic, educational, medical and social. The Constitutions say this:

“Let each sister see Jesus Christ in the person of the poor: the more repugnant, the work or the persons, the greater also must be the faith, love and cheerful devotion in ministering to Our Lord in this distressing disguise.”

There is the sound outside of trams, and there is the brilliance of the light slanting in on the bare red floor.

We continue to wait. The charts record the year in which each new centre has been established. Twenty years have seen the work spreading out not only to other parts of India, but also to other parts of the world—Ceylon, Australia, Tanzania, Venezuela, Italy, are among the countries in which the sisters have established their missions. Aspirancy is three months, postulancy is two months, the novitiate two years and in all nine years must pass to the final vows. A chart lists the qualities expected of a candidate: Health of body and mind, ability to acquire knowledge, common sense in abundance, cheerful dispositions. Poverty, chastity and obedience. Obedience means freedom.

We were sitting down talking with her.

“There is something very beautiful in Calcutta. The charity of the people is very great. I will give you an example.” Her face is lined, her features strong, her manner direct and unadorned. She smiles readily.

“This happened. I knew of a poor Hindu family that was starving—the middle class would be shy to help them. So I took two kilograms of rice. The woman kept one kilo for her own family—this would have meant only about one spoonful each—and gave the rest to the family next door. I asked the woman how she could do this and she said, ‘Mother, they have nothing also.’ The singing? We celebrate a day of peace for Ghandi.”

She came, she said, from Albania. But she had not been in Europe for 42 years. I had feared that conversation with her might be stilted, a formal meeting, a sense of taking up her time, elements of voyeurism perhaps. None of these fears was well grounded.

“We do not look for very special people to join us. They only have to be called. They are not upset by what they see, they do not need any special opportunity. But they need much spiritual training as well as training in the work. When they come we explain what our Lord has said, they are not distressed, but we have to strengthen the spiritual part. The sisters are all young. Few leave us. A girl going down for the first time to work in our Home for the Dying tending an old man whose body was eaten into by maggots, came back beaming with joy and saying ‘Mother I have been touching the body of Christ for three hours.’ But we won’t take volunteers—Peace Corps or VSO²—they need recreation as well as work and we cannot offer them recreation.”

“Do you ever take a holiday?”

“No! Every day is a holiday.”

A sister came in and called Mother Teresa to answer the phone. Again, the singing reached our awareness, the clangour too of the street outside, over the wall. There are times when light and sound merge together.

“There is now a great change,” she said, sitting down again.

“The rich now come and wash and feed the untouchables. They do much work. We, as Christians, never gave them a chance before, we thought that charity was only for Christians. I thanked an educated Bengali woman who had been with us and she said, ‘Oh, Mother, it is I who thank you, you have given me the chance to do something beautiful for God.’”

² Voluntary Service Overseas, a charity organization established in the United Kingdom in 1958, that recruits skilled volunteers from all over the world.

We walked with her down the street to the baby home. The frenetic surging of the street's activity swept around us, the madly hooting cars seemed to be engaged in a race rather than in any ordinary civil business, the crowds on the pavements seemed to be acting out a crowd scene rather than going about their day. A fat arrogant crow was down in the gutter picking at the absurdly two-dimensional remains of a rat. A splendid decorated red Victorian postbox seemed to have strayed from a London suburb but one side was broken off. A street water pump proclaimed the embossed message: "Waste not want not 1914."

Each cot held four or more babies lying neatly side by side like packages bundles. The rooms seemed crowded with babies—there was that strange impact common to all experiences in which one sees a greater quantity of some category of objects on display than one had hitherto thought imaginable. Premature babies lay in a simple incubator and a bug, disturbed by our opening the lid, scurried into hiding. The babies were beautifully dressed in clothes that had come from many countries and some were adorned with little lace caps. Toddlers and young children rushed up to see us, Mother Teresa picking up first this one and then that one.

"If we had not taken them in, many of them would simply have died. Abandoned children. Look, the legs very swollen with malnutrition, but she gets better." Mother Teresa was holding in her arms a singularly pretty two year old, perhaps someone's favourite, for her eyes had been carefully and glamorously made up: the back of the little girl's head when she suddenly turned round was, unexpectedly and grotesquely, a mass of sores.

"This one cannot walk."

The décor had something predominantly pink about it, something absurdly reminiscent of a rather overdone English nursery. A picture of a very English rabbit was on the wall and next to it a lamb frisked. A child played on the floor with its teddy bear.

"We make them very happy here, but nothing is as good as growing up in a family. One day I saw a child not eating—his mother had died. So I found a Sister who looked exactly like a

mother and said you will do nothing but play with that child—the child got better. Every year we have many adopted by families in the United States and in England—look, here is a photograph, each year the mother sends us one—and they can give so much more. The others we send to our schools. You will come to our Home for the Dying.”

Taxis are in short supply in Calcutta, and we waited some time in the street, importuned by several beggars. As we drove along the noise of the street was such that we could only converse in shouts.

“We try now to make the experiment of helping them to do something to help themselves.” A seemingly certain crash with no one even half willing to give way. The overwhelming physical impact of the assault of every modality of sensory stimulation at maximum intensity. Mother Teresa is unperturbed.

“We try now to give some of them money so that they can buy things and then sell things. In one part of the country we have 800 girls employed making nets—such girls have no hope at all of marrying at all unless they can save a dowry of 2,000 rupees. We try to build houses for people and find work for people. Education too is so important. We start little schools in the slums. If anyone will sponsor a child we can for 45 rupees a month get that child a good education. And how is family planning in England?”

We drove down to the district of the Kali temple. The district is poor even by Calcutta standards. The previous day we had been accosted there by an authoritative bent old beggar with a stick, who declared that he was a senior priest of the temple, a retired clerk, and a loyal subject of the Queen: he forced us to accept him as a *de facto* guide by his extraordinary adroitness in a sort of anti-shadowing which enabled him always to be two steps in front of us whatever way we turned. We had on that occasion walked straight by the Home for the Dying without any notion it was there.

“Home for Dying Destitutes” was written in white figures on some black boarding at the doorway, and beneath was the translation in the flowing characters of a native language.

Inside it was rather dark. The smell was remarkably slight. On discoloured but clean mattresses rows of the sick lay on the floor. The structure of the building was unusual—a sort of raised stone platform ran on each side of the circulation space and the impression was rather like that of casualties collected at a railway station—we walked along the track, as it were.

“This is our dispensary”—a not very clearly demarcated area of one platform.

“This is our kitchen”—a small area marked only by the presence of a vast pot for boiling up the food. Pumpkin, potatoes, some mutton, was being prepared. Chalked on a board was the day’s occupancy: men 64, women 67. On the wall there were some plastic flowers.

“We take only street cases—people we find dying in the streets. We have our own ambulance to bring them in.”

While talking to us, she moved among the patients—a word here, a word there. Some of them were prostrate, some raised themselves on one elbow, some leaned their backs against the wall. The whole impression was of humanity broken and unable to rise. A young sister took round the tray of medicines, the familiar safe ritual of every hospital.

“The building used to be a rest-house for pilgrims coming to the shrine of Kali.”

Outside, in the sun again, the light was now less intense—the day moved toward evening—and in this street at least, the day seemed to have lost something of the fury of its tempo. On the pavement outside the Home for the Dying a quiet man had spread out in orderly fashion his wares—pieces of scented sandalwood, strings of rather tawdry beads, sticks of incense. On the other side of the doorway a vendor sold bright-coloured panties, loud primary colours and white fringes.

“You will come and see our lepers’ home?”

We drove off in the ambulance. A man, either physically or mentally ill, but in any case quite detached from external happenings, sat in the middle of the road. The driver squeezed the klaxon. Passers-by took no notice. We drove around. Later we were slowed

down by the congestion which was being caused by several groups of marching communists, red banners to the fore.

The lepers' settlement is a collection of shacks on the far side of an almost completely drained canal. A little group of men for some reason sat in circular conclave on the canal's bed, and a hen or two pecked at the black soil. A man had chunks of raw meat spread out for sale on cloth he had placed on the ground: the settlement is near a slaughterhouse, and hence the stray dogs that lie around the shack are fat.

We walked up to the main door of the hospital building along a narrow path flanked by what surprisingly turned out to be human habitations: people would suddenly appear from what was little more than a chink in a wall. The patients smiled, inclined their heads, gave their salaams—again Mother Teresa had her few words for everyone. We entered the hospital, itself no better than a ramshackle shed.

Again, there were the mattresses, close-packed, and yet as separate from each other—as discontinuous—as the blocks of sandalwood we had seen laid out on the pavement. This time the predominant attitude was one not of recumbancy but of squatting: men who had suffered every form of mutilation squatted in front of their dinner bowls. A man suffering perhaps from pleurisy, his breathing shallow and constrained groaned loudly and repeatedly: the others watched impassively. A man made a poor effort at holding a spoon with the stumps of two remaining fingers. Mother Teresa found the groaning man another pillow, altered his position, the groaning stopped.

“Mother, I am an educated man. I was a clerk in a very good position. I earned 650 rupees per month. One day the neighbors got up a petition and said his face was not properly well. The police came and said within two days I must go. I said what must I do. They say you are an educated man, make your own arrangements. Then I know only Mother Teresa will help me. I am an educated man, and my motto is leprosy is not a disgrace it is an illness.”

The low roof, the darkness, one or two nuns moving among the patients. She answered, and what she said seemed to be offered neither as a sop nor an exhortation but as a sort of clinical statement—"No, leprosy is not a disgrace, it is a gift from God."

Outside, there was the smell of wood smoke from some cooking pots and the huts looked very black in the twilight. People followed us as we walked through the living quarters where whole families were settled. Some better huts had been built with the help of boys from St. Xavier's School. Children were everywhere, the settlement has its own school.

"Mother, they throw things at us from the railway train."

Before we said goodbye that night, we talked briefly about acceptance of suffering—the advantages and disadvantages of such acceptance. "If you have the attitude of non-acceptance you suffer twice—once for the pain and then once again."

After leaving her, we walked home in the dark. The snake charmer, his troupe and his snakes had gone home now.

People camped on the pavement, cooked their meals, lay down for the night. The city was now very much quieter and it was possible to catch the sound of individual voices, animated conversation coming from those makeshift pavement tents, and now and then, too, the sound of laughter.

CHAPTER 14

1978: WHO Business and a Visit to Kenya and Zambia¹

The first major project which Joy Moser helped set up as the World Health Organization's (WHO's) main alcohol staff-person was the

¹ Editor's Note: This trip involves a meeting in Zambia organized by the World Health Organization. The aim of the meeting was to coordinate what came to be known as the WHO Community Response Project, a cross-national action research program involving epidemiological surveys and the evaluation of community responses. It was conducted by collaborating investigators in Zambia, Mexico and Scotland. Griffith Edwards was a consultant to the project, which was also supported by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA). The project resulted in numerous publications and served as a model for future international collaborative investigations sponsored by WHO.

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one which in 1976 led to the formulation of the alcohol dependence syndrome concept and its rapid take-up by the international expert community. This time we were again working within the same formula of WHO sponsorship and funding from NIAAA and with an immensely experienced support group recruited by Joy. We again had the inestimable benefit of her presence as a member of the project group and a highly experienced support group hand picked by her. This time the funding was sufficient to allow the recruitment of David Hawks as project officer to oversee this new venture. David was an Australian whose experience working in the UK project sites would allow similar projects to be established in Zambia, Mexico and Scotland. They would try to determine how families, neighbors, work colleagues, people at bus stops as much as any existing formal entities were likely to view and respond to a drinking problem. In looking at this sort of issue in a developing countries context we were probably breaking new ground. I was on the way to a conference at Nairobi (Kenya) en route to Lusaka, Zambia. Whatever the formalities of our project's intention, I saw this adventure as offering personal sensitization towards life in black Africa. Zambia had gained its independence in 1964 and Kenya in 1963. At Nairobi Airport I was met by this charming African doctor whom I did not previously have any acquaintance with. Approaching my international hotel he said: "I do not like to leave you here if you would like any other hotel in the world, I would rather take you back to my home and teach you to eat with your fingers." At the end of two days I had become adept at this skill and enjoyed much stimulating conversation of a kind which would not have been available to me in the dining room of the local Hilton.

Ernest had trained in London and had come home to a government appointment. The salary was meager but he was able to save a little money which he was putting into buying land. He told me that every African wanted to buy land as the only proper precaution against political and financial instability. He said that the drink problem certainly affected the urban poor but it also was severely damaging to the new urban professional and almost

always Western educated elite. To his knowledge the first three medical doctors trained abroad had all been killed by their drinking problems. He described the story of the London trained doctor who had given up his consulting room and operated entirely from the bar of a hotel. He never interviewed or examined a patient but would send his secretary out to find out what was wrong. After reporting to the doctor, the secretary would return to the applicant with a scribbled prescription and a request for the bill immediately to be paid so that his whisky habit was funded. The next day I met up in a hospital with Wilson Acuda, an able former registrar of mine who had trained in Uganda in the days before Idi Amin. His brother was an aide-de-camp to Amin and in football matches protocol required him to lose. He motions me to enter the outpatient department waiting area while he offered simultaneous translation. There appeared to be no word for “depression” but he confidently described the symptoms of that condition and the people talked about being tired, and as manifesting diffuse somatic complaints. Back in the street Wilson and I found the road blocked by a cavalcade which was escorting President Jomo Kenyatta. The street was densely lined by police and I was lucky to recover my confiscated camera—photographing the president was for some reason disapproved of.

Then during the flight down to the Zambia in the company of Wilson Acuda, Robin Room, Dick Jessor (a social psychologist) and Lee Towle (NIAAA staff person) we had to take a detour to avoid overflying Tanzania. We were met at the airport by Alan Howaith, a British expatriate doctor who at an early stage in his career had been a prison medical officer and carried books into a political prisoner, Kenneth Kaunda, who at this moment was the president of a free country. Alan took us to the main hotel, a lively type of place with much noisy beer drinking going on. In the afternoon a group of us wandered the streets and went to a market that was contained within a walled enclosure. All life was there at play, a tapestry, a statement. In one section, stall after stall of dried fish. In another you can get your shoes mended. Yet elsewhere people were making furniture with an adjacent patch given over

to the making of tin cups. Live chickens for sale, tradesmen and women at work.

I had dinner with the whole work group in the evening. Calderon Navez, a Mexican colleague, spoke about psychiatric presentations in hospitals in rural Mexico and he said the story was incredibly like Africa. The next night we moved over to the Ridgeway Hotel, one of those hotels which are a memorable delight. A great fish pond at its centre, fountains in front of the grand entrance, not long ago black people would not have been allowed into this hotel. We went in the morning to Chaimema Hills Hospital, the capitol's main mental institution. Despite our host's performing instincts, the sights we encountered were sad and familiar. The courtyard was bustling with activity, patients rocking, silent, or just lying around. About 160 medical personnel, many of whom were psychiatric assistants with three years of training. By October the year's supply of drugs was running out. One assistant may have a parish 200 miles long and have to try to intervene in a distant parish where he finds a psychotic man tied to a tree with a bicycle chain.

We visited several shanty towns and just walked the streets. Children were following us in hordes. People were gathered here and there. Later we visited some local bars, the only relaxation on offer for the community. Much drunkenness to be seen to the point of passing out. A man showed us a woman on the ground and kicked her. We were told that when he would have been drinking it is right to beat your wife and she would be disappointed if you didn't do so. You let your girlfriend go to the bank and not your wife, for your wife cannot be trusted to understand money. A man tells us that his friend was run over drunk and that is a common event, and otherwise in the evening people will fall over drunk in a bar and hurt themselves badly. I now have an enormous spider that I've just seen running across my bedroom floor. It's not poisonous.

Monday 2nd of October. Meeting at university campus as Mexicans and Zambians discuss ideas on how to overcome difficulties in mounting their surveys. Back to hotel in time

for pre-dinner swim. At sunset the sky displays delicately and softly the brilliant colours of the day. The vice-chancellor's party in the evening.

In the morning I notice the astonishing brilliance of the flowers and greenness of their leaves as they grow from planters in the hotel garden. Children who want to shake hands, the sun and the heat are the dominant and central factors today. With predictable inefficiency, everything breaks down and everyone is always late. I chair the afternoon session and have to deal with an American academic who is cross because he does not think his ideas are receiving sufficient attention.

This is my fiftieth birthday. I thought it was appropriate to mention this fact to my colleagues. But there in the hallway is a big birthday cake which in the shortages of this city must have been derived from the infinite searching of markets. And a red rose. I am so deeply touched by this kindness of strangers. After supper I would have to sit down and write a position paper summarizing what little we know of how drinking problems manifest themselves in developing countries.

Wednesday 4th of October. With writing responsibility I am unable to accompany the rest of the group on a fascinating visit to observe drinking at traditional beer garden restaurants. Later in the afternoon I tape record material on culture and drinking with one of our drivers and his friends. I later worked out these notes as an article which I published in the *Lancet* and this is an excerpt.

* * * * *

This is the transcript of a conversation with four Africans one afternoon in a hotel room in Lusaka. Banda was 38 and worked as a driver. Daka was a mechanic aged 31. Moyo was 31 and a postgraduate student, while Mudenda was a 32-year-old medical assistant. Banda and Daka came originally from the Eastern Province and Mudenda from the Southern Province. Moyo had grown up in Zimbabwe. Banda did most of the talking.

The editing of the transcript has been kept to some reordering of material and minor tidying-up; we have left the original phrasing with all its freshness.

We would not claim that the evidence of just four witnesses can speak to the drinking patterns and attitudes of a whole complex society which is undergoing rapid change, and the experiences and beliefs of each of these people are to an extent idiosyncratic. But at the same time each of them is speaking from a cultural background.

Drinking to Get Drunk

G.E.: How does a man drink in this country?

Banda: I drink nearly every type of beer, including local brewed stuff, and I'm not a moderate drinker, but someone who is a heavy drinker. And I'm a drinker who has never been involved in any problems at all. I have seen other people ending up in police cells, divorced because of their drinking. Problems are very common, especially at the month-ends when people get so much drunk, and then they feel they can shout anyhow because they have got money and they can pay the police, and they can kick anybody anyhow. And I would say people drink more bottled beer² at the month-ends than they can do at the middle of the month. During the middle of the month you find that they end up drinking opaque beer,³ or locally brewed stuff.

G.E.: Which do you prefer, opaque or bottled beer?

Banda: I prefer both because when I'm broke, I can go for something cheaper, and when I have got some money, I can go for bottled beer.

G.E.: Do you drink to get drunk?

² Bottled beer is of lager type and contains 4% alcohol v/v.

³ Opaque beer is the commercial form of traditional beer and is unfiltered (hence "opaque"). It generally contains about 3.5% alcohol v/v.

Banda: Yes, what is the idea of drinking, drinking is to get drunk. You shouldn't leave a bar when not yet drunk.

G.E.: Do you drink alone or with friends?

Banda: I never drink alone, I just drink with friends. Partly for defense because if there is anything wrong, then my friends can defend me and when I am drunk, friends will take me home to sleep. Beer is something we get for entertainment. People spend more on beer than on food because most Zambian wives do not know how much their husbands get. For example, if I get something like K120⁴ per month, I will only take about K60 or K70 to my wife and pocket the other money which will be used for buying beer.

G.E.: Is there anything in life as good as drinking?

Banda: Apart from drinking, nothing. I think drinking is good. Otherwise, apart from drinking, nothing is good and it wouldn't make life tolerable.

G.E.: If I were to go to one of these "unauthorised" townships,⁵ what would I find for a man to do in the evenings or on holidays besides going to a bar?

Banda: Well, I think in a place like where I come from, there is very little social amenities, there is nothing. Play with the children or jump about. Otherwise there is nothing else you can do besides going to a bar. The only social activity is the tavern or bar.⁶

⁴ Kwacha (K) 1 is roughly equal to \$U.S. 1.2. 100 Ngwee (N)=1K.

⁵ Settlements which were previously referred to as "squatter townships". Much has lately been done to upgrade their facilities.

⁶ Taverns are of two types. One is the municipal tavern which can accommodate 200–300 drinkers, mostly in the open-air. These establishments might be seen as scaled-down versions of the old beer halls, which could accommodate upwards of 1,000 customers at one time. The second type of tavern is privately operated, and mainly distinguished from private bars by the fact that opaque rather than bottled beer is sold.

Moyo: My experience at the university was that most students drink because, if a student goes too long before he drinks, there is some confusion which takes place. My experience shows that after reading seriously for one week, one ought to relax for one or two days. One should get a drink as a means of relaxation. A lot of students have done this and it helps to create motivation for the next week. I think there is some kind of direct relationship between drinking and hard work. If someone works hard, he is to be rewarded by a beer or two. And perhaps this is why most students are known to be heavy drinkers. It is because of reading.

Women Should not be in Taverns

Banda: Women, they are also human beings, they are supposed to drink anyway, but not as much as men. I would say that we men are stronger than women, I wouldn't like my wife to get drunk or drink at all.

A.H.: How often do you see women drinking in taverns and bars?

Banda: Nearly every day. They shouldn't be there, they should be at home. If a woman is drunk she sometimes falls with a baby, and sometimes they feel shy to take out their breasts to feed their babies and if a baby cries, they just give a baby beer to drink and the baby becomes drunk, and sleeps. So that children start drinking beer at an early age. I think it is very common.

Children

Banda: Some mothers send their children to buy beer from taverns and they drink at home. Sometimes children can buy beer too on their own and hide somewhere and drink away from the parents.

A.H.: And children are allowed into the tavern and buy beer even though they are young?

Banda: Yes, they are allowed in taverns even though there is a notice on the door saying that children under 18 years should not go into bars. This is never strictly observed. We see a lot of school children getting drunk.

G.E.: Is it all right for children to drink?

Banda: No, it isn't. The right age for my son to drink is, say, 25 or 30 years.

Daka: My grandmother said "It is beer, but it no good for you because you are still very young". However, I managed to get my grandmother to give me just a little cup of the opaque beer. After taking it actually I had quite a good time. I could see things. Then I was about 11 or so. From that time I never took beer until I was about 14. My father and mother used not to drink beer. They were Christians. But my friends at school, after school we would get together, get a gallon tin of opaque beer, and drink it. We used to get high, and we would not report home until late so that our parents would not detect that we had taken some beer.

Opaque and other Beverages

Daka: The various types of beverages that I know are Chibuku; it is the commercial opaque beer. It is made from maize meal and finger millet.

Banda: *Mbamba* is bread, sugar, maize meal, and yeast. Then there is this thing which they call *Solopi*. *Solopi* is brewed in a rather funny way. They just take some sugar and yeast. Fry them and put in water. Then they let it cool and it would be ready for drinking in about 30 minutes.

Daka: There is *Kachasu*. The process is about the same except that it is distilled. It is yeast, sugar and maize meal, and bread. This makes a very strong beverage. Then there is *Sikokiaan*. The ingredients of *Sikokiaan* are beans, sugar, and yeast, and maize meal also comes in again. It is quite a dangerous brew. People used to drink it in the bush. When they came from the bush they would be fighting because they are drunk.

Banda: The brewing of local brews is not standard. It differs from place to place. For example, when brewing *Kachasu*, urban women use sugar but in rural areas, they use fruits like *Masau* or bananas. In Lusaka, I am sorry to say this, but my wife brews *Kachasu*. In the brewing of *Sikokiaan*, if beans are not added you get *Mbote*. There is *Mbote* which is honey beer and there's *Mbote* with beans.

G.E.: What does opaque beer cost?

Banda: It's cheap. The 15 ngwee one is the smallest tin, and the 30 ngwee one is the medium tin, and there is one they call the "upper-role", which is 75 ngwee.⁷

Bars, Taverns, and Shebeens

G.E.: What is the difference between a shebeen and a tavern?

Banda: The shebeen is an illegal place and a tavern is legal. Beer in a shebeen is very expensive. Shebeen is a private house and time is not controlled. When all the bars and taverns are closed, people would go to shebeens because there is no other place they can go to. I would not prefer to go to a shebeen at all. When you buy beer for certain amount of money in a shebeen, the next time you want some more, you may be given credit. Then you pay at month-end. This is the only attraction about shebeens. Sometimes too, beer in shebeens tastes sweeter than beer in taverns or bars. The shebeen queen sometimes adds in something to make it taste sweeter. The beer in taverns or bars may have been there for several days before it is sold out and it loses its freshness and then people do not like to drink it anymore. They go to shebeens where it always tastes fresh. Also, there could be boyfriend and girlfriend relationships.

⁷ The largest tin contains about 1,560 ml. The expression "Upper role" refers to the old voting roles, before independence, when the white (richer) people were on the upper role.

Drinking has Changed

Banda: We drink more since independence and even the police do not take much control of the selling of illicit beer. During colonial days people used to drink these beers away quietly in the house or bush.

Mudenda: I was brought up in a village. At home, drinking is only where there is a ceremonial occasion or a feast is going on or somebody is getting married. The way we drink in town is quite different from the way we drink at home. At home, for example, during the rainy season, if one had a large land for farming, a mother would brew some beer to invite people to do some work on the farm. And at the end of hard work, they would come home and start drinking. They drink for the work they have done on the land. Or somebody is getting married, they brew some beer and drink as part of celebrating. Where there is an initiation ceremony, when a daughter gets matured, beer is brewed by the mother, the owner of the daughter.

Daka: On certain occasions people are going to brew beer to appease the spirits of the dead. Like the times when we have drought, in typical villages they say, "Why has it taken too long for the rains to come?" They think that someone has annoyed the spirits. So they would brew plenty of beer. Some of it is taken to the graveyard and some of it is drunk by the people. When they are offering this beer to the spirits they say a few words, plead with the spirits for whatever they believe to have gone wrong. These days, however, they are tending to draw away from this.

Banda: In some parts of the Eastern Province where I came from, when you have got long fingernails and you happen to go to a place where they are drinking, people will try to avoid you, because there is thing they call *Luanga*. This is some kind of poison which can be put in fingernails and then let fall in a tin of beer which you may offer to someone to drink and he then gets poisoned to death. In the villages we

try to choose with whom to drink. For example, when I went to my wife's village, my mother-in-law had prepared beer for me. Before I drank I made the brothers-in-law drink first. So I waited for five minutes to see if anyone collapses. After I found that nobody collapsed, I started to drink as well. Also, I had very long fingernails and one of my brothers-in-law advised me to go and cut them. So I cut them on that very day, to make friends.

Daka: In this country we cannot say this type of people drink and this type does not drink. Because even at home in the villages, all the villagers drank. It is only the pattern of drinking that has changed due to urbanisation. The villagers used to drink not to get drunk as such, but as a means of relaxation after a hard day's work. But now there is a tendency of everybody wanting to drink because they have nothing to do. People with money, they have got servants to do the work for them. And there is very little for them to do at home. They may read, but when they get fed up of reading, they will go to the bar.

Banda: If we have to ask why people do drink or why people shouldn't drink, well, the Government has built taverns and bars, etc. These places are to be used. Otherwise if we do not use them, we do not contribute to the national revenue.

A.H.: What do you think about the way the *Apamwamba*⁸ drink?

Banda: It is hard to tell how they drink. But I know of some who visit my area. When they come there, they don't buy one bottle, they buy about a crate of twenty-four bottles. And me who is lowly paid, sometimes, I happen to compete with them. Where they buy five, I also try to buy five. For example, I have got a friend who is with the Government, and he has got a fat cheque. When he comes to my place, he buys so much beer and I feel that the next time I have money

⁸ *Apamwamba* means "those who are on top".

I happen to do the same. Then end up without any money for taking home. Generally, anyway, they drink in different places like Hotel Intercontinental, Ridgeway, and places like that.

Churches

A.H.: What do you think of the churches in Zambia with respect to drinking?

Banda: Well, for people like the Catholic Church members and the Watchtowers, their members do not drink too much, but it appears that at this time the churches do not seem to be very effective in controlling beer drinking. They tell their members to drink not too much, but just drink a little. Now how little one can drink, we do not know. For example, my mother is a Christian and her church does not allow her to drink too much, but drink a little. When I go home, I find my mother staggering after taking beer. I say to her "Mother, the Church says you should not get drunk". Well, she would say that she had just drunk a little. Look at that one falling over there. He is the one who has drunk more. Now if you say that the church has played a big role in controlling beer drinking, it is just a big role while they are shouting at the church premises.

Drunkards but not Alcoholics

G.E.: I would like to know in this part of the world what expressions there are for being drunk, or alcoholic.

Banda: The only thing we have is drunkenness-*kukolwa kwambiri*-somebody who is very drunk. But we do not have words like "alcoholic". These things are new to us here in Zambia. People are not educated to know what problems beer can bring to the body. People do not know that there is such an illness as cirrhosis caused by alcohol. So we just know that this

person drinks so much, but we don't know that there is such a thing as an alcohol problem.

Mudenda: I would say we have got some drunkards actually. Not alcoholics as such-as it is in Western countries. We have got some drunkards of course.

G.E.: You have a word for a drunkard?

Mudenda: Yes, "*Ba chakolwa*". He has a habit of getting drunk almost every day. It is a nasty word. It is not nice to say to somebody that you are a drunkard. It is very annoying, even though you are aware that you really drink.

G.E.: Are there different words for degrees of being drunk?

Daka: Well, we have such words. We may describe someone as being happy when we really mean that he feels high or has taken something intoxicating. We may say that he is happy today, when we actually mean that he has taken some alcoholic beverage. And if you "*Chakolwa*", it means that he is filthy drunk. Somebody may say "*Chipuba*". This will mean somebody is drunk to the point of misbehaving. Somebody is a fool.

People are not Interested in "Help"

G.E.: What do you think about a very drunken man?

Banda: I feel there is enjoyment, that is all, there is nothing wrong, no pity. Provided he has not fought anyone. He is just staggering or falling. He hasn't done anything wrong if he falls down. He has committed no crime. He has spent his money and he is falling over and he is drunk.

G.E.: What do you think about people who don't drink at all?

Banda: I think people who don't drink also have their own loose morals anyway.

G.E.: What sort of troubles have you seen with your friends?

Banda: Well, I witnessed many friends ending up in police cells for beating their friends or for public misbehaviour say. One of my friends was run over while drunk. It's common. People fall down and sometimes do all sorts of things, but when friends are there, they take them home. Many times a knife is used.

Daka: I remember one time, it so happened that I had a broken engagement. At that particular time I started drinking

so heavily and I could finish two bottles of brandy per night. Until I find somebody new who persuaded me not to drink too much. So for somebody to look for help in as far as drinking is concerned, it is just not on. People do these things deliberately. Either somebody drinks too much because he wants to, or he feels that he should drink too much because money is available. If there are people who would like to help in this respect, or an association, it would not function properly because people are not interested to consult them.

Shakes and Possessions

G.E.: Have you ever heard of someone who drinks having their hands shake?

Banda: Well, I have had mine shake. But I did not know it was because of alcohol.

G.E.: Do you drink anything in the morning to get rid of it?

Banda: Yes, mostly water. I drink beer if there is beer.

G.E.: In Zambia, outside the English language, is there any concept of delirium tremens?

Mudenda: That is a new concept in the Zambian way of thinking. They would give a different explanation. They would say he is probably possessed by some spirits. They wouldn't think it is due to alcohol problem. In Southern Province, if someone develops delirium tremens it could be due to her suffering from these spirits-*Mashabe*⁹ problem. They would never think it is due to alcohol problem, but they would think there are some spirits which are possessing this particular individual.

Banda: The thing is, people who shake, they do not know that it is an alcoholic problem. So they may end up drinking more. The patient may say "my *Mashabe* need more beer". So he will continue drinking beer. He would never get cured because he may say that "I am drink-

⁹ Mashabe is the general name given to trance or spirit possession states.

ing because of my Mashabe". And when you give him beer, he stops shaking. And you are convinced that's his medicine. This is what the spirits need.

It Needs a Lot of Discussion

Banda: Reducing or stopping beer drinking is not simple at all. People would not like it. But I would say that if they want to reduce beer, they will have to reduce the amount of liquor licences. Or some tavern owners should not be allowed to renew their licences. But there again, there will be congestion in those bars which will open, and people will start fighting for beers. You see, we are dealing with a very difficult issue which needs a lot of discussion.

* * * * *

5th of October. I am going out for a short break in the afternoon. It has been a day of hard work on the project with real feelings of progress and much solidarity established. I have such a sense of personal privilege in being allowed to join in this exercise. At 8:30 pm, there is a meeting of the whole group for a discussion of the future of the WHO Alcohol Program (and suggestions for revision of my paper). All very useful but Joy's position even more uncertain. Afterwards I discuss the situation with David Hawks and we consider whether this might be a moment to appeal directly to Tom Lambo, the Deputy Director General of WHO, with whom I have personal contact.

26 October. Much thoughtful discussion on how we are ever to turn research into action. Then we all went out to the President's house for lunch. We had to wait for five minutes at the gates while the stream of ambassadorial cars drove out. A large colonial house which had previously been the governor's residence, peacocks screeching horribly. An entrance with an angry head across the door as we crossed into the hallway. Many portraits of the person we wait for. In a sunny drawing room the door opens and a hot but refreshing wind begins flowing towards us. Comfortable

pale colored chairs and sofa. Several modern pieces. I chat with the Minister of Health who is a young gynecologist devoted to his position and is otherwise the president's personal physician. The President arrives about three quarters of an hour later. Tall, heavy, grey haired, white shirt with open neck (see Fig. 14.1). Coloured handkerchief in his breast pocket. We get the large impression he had in the extreme the African habit of rarely smiling and laughing. Enormous presence. Not quite a bishop, certainly not a soldier. We shake hands all round; we move into the dining room. A flower set table and good silver. The person who was asked to say grace is chided by a colleague: "I hoped you would say something original but you Catholics never do". We eat with fingers. David Hawkes tells me afterwards that the lunchtime conversation on his side of the table turned to Christianity and his view of Christ as a revolutionary leader. As one person noted, the President Kaunda tunes into the BBC overseas service and all fall silent while he listens to his chief intelligence source. David afterwards told me that Kaunda had during a recent holiday been writing the study of Christ. He talked about Christ on the cross and said that Christ's death was not just for spiritual freedom but also for physical freedom. He says to attain the freedom, violence is usually required. He suggests that Christ could be understood as a freedom fighter.

Lunch is enormous, a feast. Piled onto one plate are chunks of chicken, hunks of meat, stew, more meat, maize, potatoes, cabbage, carrots, beans. Afterwards the speeches and then the President takes us back into the drawing room and pours coffee for each of his guests individually while the minister of health offers the cream.

In the evening I go to a party and talk to an African economist and his wife. She gives me a detailed picture of the British life in the place where she grew up where her father and mother still live. Her father has retrained as "a reverent". Supposedly he has now quit his heavy drinking but he will still have some brandy if he can get hold of it.

Saturday 7 October. Caught the early morning flight to Livingstone. Lovely old twin prop plane. It was a very comfortable take-off. Rather dry but substantial sandwiches served on our flight seemed in keeping with the antiquity of the plane. Tourist bus to



Figure 14.1: Griffith Edwards shaking hands with Zambia's President Kenneth Kaunda in 1978.

the hotel at Victoria Falls, then walked to the Falls themselves. A contrast between the slow diffuse waters that lead up to the edge and the rushing falls. Little figures standing on the rocks in the Zambezi, fishing. The cliff faces themselves intensely beautiful. The water falls with such force that it springs up again into the air; the sun catches the spray and there are rainbows. Only a few tourists. We follow a little path around palms. The roar of the water but otherwise tranquility.

Then the long night flight home back on our familiar twin prop to Livingstone and then on to a British Caledonian jet. Shared the journey with the egregious Ron Roizen. Dashing to Victoria, taxi. Took the children by surprise at their supertime. Much rushing into arms. We then drove to pool for a swim, golden English autumn weather. Such happiness.

CHAPTER 15

1989: Exchange Visit to All Union Institute of Narcology¹

Sunday 19th November. We leave at 6:15 am for Heathrow. We get there in under one hour, kind Sue (Edwards) driving. Meet John Strang for breakfast. Take off for Moscow at about 10 am, three and a half hour flight. Crossed Denmark, flew over the Baltic and then for me the first ever view of snowy Russia. Arriving today

¹ Editor's note: This trip took place during a remarkable period of the so-called "Cold War" between the former Soviet Union and the Western countries. As a result of General Secretary Mikhail Gorbachev's reform of the Soviet political and economic system, scientific exchanges were organized between the USSR and several Western nations, including the UK. These kinds of high level bi-lateral exchange visits were designed to relax diplomatic tensions by fostering research collaborations on topics of high importance to the two countries. They played a key role in the reform movement's implementation of *glasnost* (openness) and *perestroika* (restructuring) and resulted in numerous international collaborative studies on issues related to addiction science.

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Figure 15.1: Griffith Edwards and John Strang.

with our luggage, which then comes into a carousel marked Budapest. We are greeted by a young man called Konstantin Voronin. MD PhD says his card. It is cold, a few degrees below zero, and dark. A general sense of drabness and lack of colour. Our car is waiting, a big Volga with one headlight knocked out. Car is there but not the driver – he has disappeared. After some fifteen minutes or so the driver appears, but he cannot open the boot. We drive for thirty minutes or so through a little countryside, then concrete suburbs, then the wide boulevards and by Pushkin Square. We have to search for our hotel, Oktay Brskaya, and no one can give us the directions. When finally located it is strangely anonymous with no name over the door. It is a hotel of the Central Committee of the Communist Party with a few rooms allocated to Intourist. John and I share a bedroom: functional, a slightly upmarket council house style, the lights too bright, a lot of bare wood, a glass-topped coffee table, garish carpet, a cupboard with some teacups. The hotel clerk says “Comrade! You have come to Moscow, hero city of the Great Patriotic War and capital of the

Soviet Union". We dine indifferently in a grand overlit dining room with a television in dominant position at one end of the room. Our fellow diners appear mostly to comprise party delegations. They eat caviar but we decide that we can't for the present afford this luxury as we have only managed to exchange 20 rubles. I try to ring home but the system will not function. Off then to the All Union Institute of Narcology and up a decrepit staircase. We locate an office which is adorned with a colour photograph (actually tinted rather than coloured) of Lenin. And there is a touched up wartime wedding photograph standing on a table with cranberry juice and bowls of chocolates and bottles of orange fizzy soft drink. A calendar has galloping horses. The view from the window is of concrete council blocks and draped washing. Professor Ivanets, head of the All Union Institute of Narcology, greets us, a small, unimpressive man with gold teeth and an untrustworthy look about him. The director of research was also present, Professor Anokina, expensively dressed and coiffured.

Monday 20th November. John and I discussed science with our hosts. They claim to have 200 scientists and 200 clinical staff in their centre but we subsequently find out that all union centres have this staff level. They talk of complex matters entirely within a biological perspective. Ivanets and Anokina unremittingly lecture us while John eats a tart and I nibble at chocolates. We see additional professors, respectively, of epidemiology, psychology, and clinical work. We lunch at a nearby café which is owned by a cooperative and serves rissoles only. We are told that private enterprise is these days better. And the temperature has dropped precipitously to several degrees below zero. We walk through some good 19th century (they say 18th century) streets. A secretary who is on her way home guides us to the metro. On the black market, the special exchange rate offers 10 rubles rather than 1 ruble to the pound. We go to the GUM department store for two pounds each. I buy three wonderful furry rabbit skin hats. The Moscow street scene is one of hurrying, silence, people in dark coats and fur hats, an absence of adrenaline. A sudden view of St. Basil's and the Kremlin wall. Back for 6:15 pickup for ballet,

accompanied by Konstantin and our interpreter Marina who is a small, dark-eyed, easy laughing, round-faced, intensely Russian language student who does not entertain any optimism. She says "I will never visit your country. Change may look better on paper than it does in reality." Konstantin is watchful. Before the ballet she and he take us to the hard currency shop which is situated in the biggest hotel containing Woolworth style china and fur hats at eight times the price we had seen at GUM for poor jewelry, cigarettes and drink. Offers of a highly unfavourable exchange rate despite notice to the contrary. Marina tells us that the average salary is about 200 rubles per month. A doctor might get 400 rubles. It is difficult to translate those sums realistically into sterling but 200 rubles might be £400-£600 say (very rough guess). Long wait to buy any car and then you'll have no choice. So on to the Ballets Rousses at the Bolshoi theatre. Audience includes workers as well as the obviously better dressed. Programme in the first half consists of numerous excerpts from well known ballets. Second half was the first performance of "unusual maneuvers," a rustic Italian love story. What was striking about the dancing was the verve, the near acrobatic style, the attack, the energy, the jokes rather than dancing to touch the soul. Audience for the most part claps quietly with occasional outbursts of enthusiasm. Marina likes it. Back to the hotel by 10:30 pm by which time no supper is being served and our request is met with laughter.

Tuesday 21st November. Wake to rather warmer weather; a sprinkling of snow is falling. The sky uniformly grey. Walk over to the Institute Laboratory, reached through a gatehouse guarded by police and embedded in a concrete hospital complex. Anokina sweeps into her office after a 5 to 10 minute delay. Goes over to a mirror, combs her expensive hair. She talks about her work and then follow another series of brief presentations from about 12 different members of her staff; her laboratory directors tend to be men and the other ranks women. Many of the women look worn, badly dressed, peasant-like while two or three others of a brighter and more modern image. Tremendous concentration on biological research. A feeling of their having been forced to present to us, a

guardedness and on questioning a retreat to generalities. At 12:45 pm, we are picked up at the door by a chauffeur-driven Rolls which takes us to the British embassy lunch with Sir Roderick Braithwaite and Lady (Jill) Braithwaite. The embassy is a mansion built in 1890 by an Ukrainian sugar merchant and it overlooks the Moscow River and the Kremlin. Dark wood, high ceilings, portraits of kings and queens, photographs from Kenneth Baker to Margaret Thatcher, and Pink Floyd. The ambassador is relaxed, confident, a sense of the undergraduate behind the man, his wife easily establishing that she was there in her own right, interested and interesting; also Dr. Lipman the embassy doctor and his wife present. The ambassador talks with seeming lack of constraint. His wife questions him and he says "I don't give a damn if this place is bugged, I know that it is bugged". He says these are stirring times and unique, history being made, exciting to be here. Says "Russian people have been slaughtered by their leaders for centuries and when not slaughtered, regimented; hence problems in morale, a difficulty in overcoming helplessness and the belief that you always leave action to someone in a solitary position". He saw Mikhail Gorbachev as an "unnecessary accident" wrong turning that need not have happened. At that time the trading, bourgeois, middle class society was evolving and hence the Ukrainian sugar merchant and a Russian based capitalism. He referred to the miracle of the country actually holding together, a vast tract of poverty and underproduction coupled with unusual and dangerous military power. He talked about the importance of the Armenian earthquake while showing the Russian people the honest generosity of the West. Back to the hotel driven by the same impressive uniformed chauffeur who we later discovered was a KGB agent. We walked through slush and cold in the evening with two scientists from the centre to something roughly equivalent to the Palladium which was held in a vast and unprepossessing hall otherwise devoted to meetings of the Central Committee. Gorbachev walked these boards. With all due gratitude to our hosts, an excruciatingly boring occasion, a little sentimental ballet, folk dancers, acrobats, a Red Army group, jugglers, pop singers, and stand-up comics who looked age 60 and

wore business suits, taking 20 minutes to reach an uncertain punch line. Then to a girl balancing by one hand on a man's head with her legs in strained positions. Her third performance is set to music and I hear myself saying "very interesting" and "ha" with an increasing awareness that my face is paralyzed. Back to our hotel for another supperless bedtime.

Thursday November 23rd Back to the centre, Marina with us. John and I are due to give lectures. I had given them a copy of my forthcoming paper (1) for the *British Journal of Addiction*, entitled "Withdrawal symptoms and alcohol dependence: fruitful mysteries". This is a computer assisted textual analysis which tried to report on things people actually said about the cues for their recovery. When I said that I wanted to dedicate this to the Russian people, Ivanets had pre-distributed the paper in translated form so there was no need to present it. He then added "we in Russia do not like this paper". I could see why that paper, which actually honoured patients as human beings and assumed that they had something to tell us, was not likely to fit Russian expectations. John gave them a paper on the National Addiction Centre which they liked. In the afternoon Marina accompanied us to the Pushkin Museum and I was again persuaded that to see pictures now and then is essential for a happy life. Said hello to several Impressionists and Picasso's Boy Standing on a Bull. We then go back to our hotel where the KGB man standing at the door tries to bar Marina. We take her in, sit her down, exchange addresses. KGB man comes up to us and says something evidently spiteful and vicious. It turns out that he is accusing her of being a tart. He then turns on his heels and walks away. Marina interrupts her conversation, goes silent, something had broken, then I see that she is silently crying. Infinite, unbearable desolation. I give her a clean handkerchief and say, "I always make girls cry" and that slow joke forces her to laugh. Then comes a denunciation. This country, this Russia, they can only treat people with cruelty. Her country in which people do not matter and are forever directed by bigger people. Letters opened without even a pretense of concealment, the direction as to where to work, the parents defending themselves

from the outside world, friends retreating to drinking and affairs. An astonishing, vivid, appalling while searing indictment. She says “I will die angry” and I say “never stop being angry for they will have broken you”. That is some ultimate message to shout about. Evening, we go out to the Belgrade Restaurant with Ivanets, Anokina and a man from Tashkent who is in Moscow to have his thesis examined. It is like entering a fortress. The choice of drink is either vodka or brandy. I ask the man in Tashkent what is the national dish and he says pilau rice with fish kebab. The conversation would be dead if it were not for John’s gift for high spirits and generous engagement with all around him. We are turned out of our restaurant at 9 pm, say farewell to our sole, ugly KGB man on the doorstep; he takes his revenge and stops Marina from entering the hotel.

Wednesday 22 November. Picked up in the morning by the big black Volga, taken to the All Union Clinical Centre. About 30 minutes’ drive with the snow falling. Thoughts of Marina; she says that she now goes to church. Not regularly, but when she feels she needs it. Her mother thinks she is going for the wrong reasons. What has altered under Gorbachev is that you can talk more openly but it is all talk and nothing practical happens. There is a shortage of soap. Her father used to belong to the party, it is a way of getting ahead, but she would never herself join. You have to pay 10% of your salary over to the party. The Clinical Centre is set in the grounds of Psychiatric Hospital Number Twelve, in a cluster of unprepossessing concrete blocks. So much better than the situation in Bulgaria, where the hospital is clean, patients have their own clothes, and the doors are unlocked. I am only worried by the fear that our presence has generated a set piece show². A doctor produces a bottle of vodka from his pocket. Ivanets frowns, no one drinks here he says. Lunch always ends with a box of chocolates.

Friday 24th November In the morning we go over to the Centre and sign letters of agreement with Ivanets and Anokina. They edge

² A set piece is considered the showiest and most memorable scene in a film.

away from anything substantial, don't want general exchange, don't want free diploma places. But they do want return trips to London. We then go sightseeing around the Kremlin. Biting wind, freezing cold, I finally do not dare take off my gloves even to photograph St. Basil's Cathedral. The churches with their gold domes against the grey sky, the icons and tombs and frescoes, the people hurrying and driven by the rasping Siberian wind, the cannons, the castle walls, the black cars, the wickedness, the panoply of holy Russia, Lenin's tomb. I have seen ugliness. Monument to the Unknown Soldier, child brides dressed in white leaping out of taxis and risking death by exposure as they throw their bouquets down by a gusting eternal flame. We shop again at GUM and buy out all available furry hats. Accompanied by a Centre interpreter called Larda who is a spoiled brat. Then back to our hotel where John and I have final celebration of champagne and caviar in the now so familiar dining room with its white tablecloths and presiding television sets. Constantine takes us out to the airport driven by the same Sasha who picked us up what seems years ago and we give him a half bottle of whisky. He says through an interpreter that he thinks we are real gentlemen and he would be glad to pick us up anytime and drive us around Moscow. The airport is reasonable chaos. Perhaps it is the dim lighting and the endless queues, the petty disputes going on everywhere, that give the airport its wonderful sense of Russian gloom; three and a half hour flight back to London. Underground to Charing Cross, train to Greenwich, then home, and in a miraculous minute there is Rosie jumping out of Sue's car and giving me a hug – and the same from Sue.

Postscript

All the preceding material comes direct from diary notes. There is however one episode that seems to have escaped a diary record and which I will report from memory. We were taken one evening out to dinner and a nightclub by Ivanets. The restaurant was a

dead place with dead food and only vodka to drink. Conversation too was dead with Ivanets informing us that it was bad manners in Russia to talk while eating. He then escorted us to what looked like any concrete housing block. We were taken up the concrete stairs and rang a doorbell. There was nothing to identify this address or what went on within. It turned out to be the totally anonymous entry to a party nightclub.

The other side of the heavily guarded door a gypsy band was playing, wild dancing was taking place, and the crowd gave the impression of being engaged in serious drinking. Warmth, bright light, shouting and cheering, an utter contrast to the frozen street scenes. I sat down and in no time was waving away a bottle of vodka. At this point a lady of mature years came over uninvited to sit on my knees. She wanted to tell me about the horrible way her father had been treated by Lenin, and how this had resulted in the loss of the family fortune. Tears flowed as Lenin's atrocity was accounted. It seemed to me likely that I was being framed by someone, with no easy way of shaking this lady off my knees. I called Ivanets over and suggested that as John and I were going to have to get up early the next morning, it might be wise to leave quite soon.

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1. Edwards, G. (1990). Withdrawal symptoms and alcohol dependence: fruitful mysteries. *British Journal of Addiction*, 85, 447–461.

CHAPTER 16

Travel: What Comes Out of It

From the itinerant's angle many of the benefits are obvious. Travel directly educates the traveler and forces him to question his own, easy, culture-bound assumptions. It broadens his network of colleagues, people who he in some ways knows, who he can call up and address questions to. He will learn not only from his individual contacts but he will get to know the complexities, assumptions, and priorities of other research centres. And he would be wise to ask himself or herself where his own team is likely to compete effectively on the international scene, and where the scene is already too crowded or beyond his likelihood of making a successful entry.

But beyond practical education and obvious professional benefits which are likely to derive from these visits abroad, I believe the vast advantage of travel for myself and the Addiction Research Unit derive from the fact that I was aged about 40 and I had personal contacts with many if not most of the important research centres and leading researchers who could benefit at the personal and more mysterious level. I had begun acutely to realize that in

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the rest of the world diversity really existed, but my assumptions were often arbitrary and limited. The need to reflect without condescension or patronage helps one to develop an acute awareness of the world. That is one benefit of travel.

Living and working in a very privileged country, I have realized there is a responsibility to do my very best to help people who work in less privileged surroundings. I learnt that there are people wonderfully attuned to meet such responsibilities. I also learnt that in many national governments in rich countries, responsibilities for health in poor countries are not acutely felt and any learning from other countries can be beneficial.

I learnt that I would have to personally address the question of how I would give reality to the one world concept. We had a dinner one evening for a group of our postgraduate students, held in our home, and afterwards I got each person in turn to talk of their childhood. It was an evening where I believe each one of us broke through barriers and reached out to each other, an occasion for which I was personally enormously grateful. And none of us was looking for facile answers to a group of very difficult questions. What I think we were seeking was affirmation that these problems needed to be identified and shared. Someone indeed suggested that we should set up the One World Club. Someone else came in quickly to say it was a club which surely should invite universal membership.

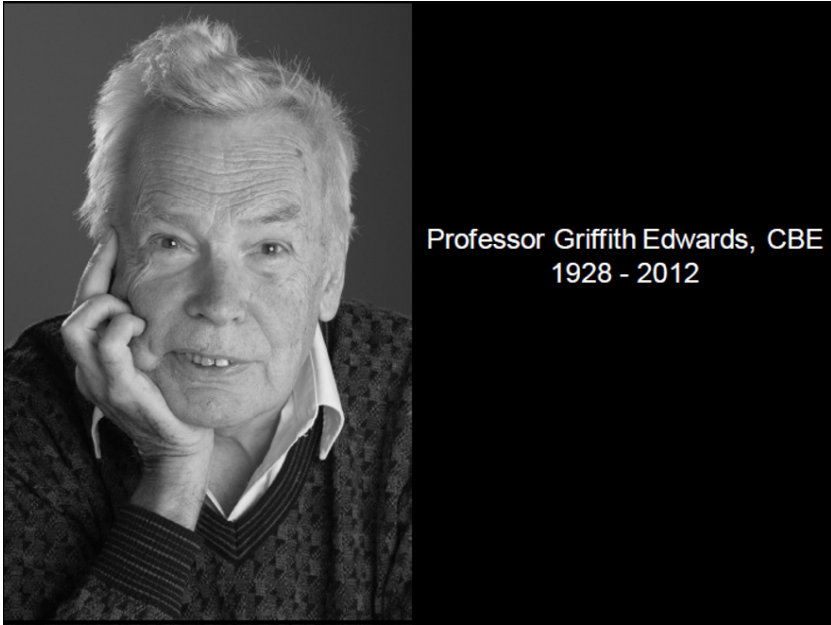


Figure 16.1: Griffith Edwards (1928–2012).

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This book is a personal memoir about the career and professional experiences of one of the world's most influential addiction scientists. Its chapters explore the views of a master clinician who learned immensely from his patients, defended their rights as a forensic psychiatrist, and translated their needs into evidence-based treatments and policy at the global level. The first part of the book is about "seeing addiction" through the eyes of a visionary who was the formulator of the alcohol dependence syndrome concept, the inspirational leader of the UK National Addiction Centre, the longtime editor of the world's leading addiction journal, the author of numerous books on addiction treatment and policy, and the always iconoclastic voice on the lecture circuit.

The second part of the book is a compendium of Edwards' published and unpublished travelogues, from his formative visits to America in 1955 and 1961, to his inspirational walk with Mother Theresa through the streets of Calcutta in 1970. From his unique lens of clinical experience and advisory work with the World Health Organization, Edwards shows us how scientific creativity is both a personal and a collective process.

As the final scientific contribution in the career of a seminal addiction scientist, the chapters in this memoir show how Griffith Edwards challenged the status quo, pushed the envelope of critical thinking, demonstrated compassion for addicted patients, questioned conventional wisdom, promoted research integrity, translated research into policy, and most of all, created institutions that continue to change things for the better.

COVER IMAGE: Central oval of James Thornhill's 1714 "Triumph of Peace and Liberty Over Tyranny" on the lower hall ceiling of the Painted Hall at the Old Royal Naval College in Greenwich, England. Public Domain via Wikimedia. Cover design by Tom Grady. No AI was used in this design. Griffith Edwards devoted his professional career to seeing addiction as an intellectual battle against the tyranny of alcohol and other psychoactive substances and of the corporate power that allows it to fester.

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