During the last few years there has been a decided boom in certain sophisticated wines – ‘dietetic’ or ‘tonic’ or ‘restorative’ beverages. Undoubtedly the public imagination has been captured by the ingenious methods pursued in pushing these productions … [Of] those most puffed in the newspapers and advertised in the press and on public boardings, it may be safely affirmed that they have no appreciable therapeutic influence other than that possessed by any of the ordinary wines on the market.¹

Throughout the Victorian and Edwardian periods, people consumed alcohol for health reasons. This was driven in part by the use of alcohol in medical practice and also by commercial factors, which played a significant role in promoting ideas about the health benefits of consuming certain alcoholic drinks. The quote above is from an article on the sale of tonic wines in the British Journal of Inebriety in 1910. The article offered a scathing attack on what the writer referred to as the ‘ingenious’ and ‘aggressive’ marketing of tonic wines which were accused of holding little therapeutic value and could potentially lead to alcoholism.² The writer, a doctor and magistrate, noted the popularity of tonic wines which were one of many types of proprietary remedies widely available in the late Victorian period. This chapter explores the issue of drinking for health in the late Victorian and early Edwardian periods by examining the controversy that surrounded the medicinal use of alcohol. Debates about the efficacy of alcohol as a therapeutic agent circulated in medical journals towards the end of the century. An analysis of hospital records
shows that although its usage diminished in the period leading up to the First World War, doctors still relied upon it to treat a range of physiological and psychological illnesses. Alcohol had been used as a staple drug in medical practice since the seventeenth century. Its usage within medicine continued throughout the nineteenth and twentieth centuries and the general public therefore had good reason to believe in its medicinal power. Prescriptions for alcohol became increasingly popular in the nineteenth century when more heroic methods of treatment such as cupping and bloodletting fell out of use. However, doctors came under attack from temperance campaigners both inside and outside of the medical profession because a prescription to drink had moral and medical implications and by the end of the century, its usage within hospitals and asylums had declined.

By the late nineteenth century, debates existed on the therapeutic value of alcohol and despite its enduring status as a staple medicine, some doctors avoided prescribing it altogether. At the core of these debates was the issue of therapeutic nihilism—whether prescribing alcohol actually did more harm than good. The effects of alcohol on health were poorly understood and medical opinions were not only based on scientific evidence but sometimes on moral grounds. In a presidential address given to the British Society for the Study of Inebriety in July 1907, Dr Harry Campbell scrutinised the contents of a recently published medical manifesto on the influence of alcohol on health. He focused on a section of the manifesto which claimed that in the opinion of the medical signatories moderate drinking was beneficial to health.

It is [according to the manifesto] the “moderate” use of alcoholic beverages that is held to be “usually beneficial.” Now, what are we to understand by moderate? The signatories make no attempt to define the word. They should have told us what they regard as the limits of moderation—how much, i.e., a person may drink daily without forfeiting the claim to be considered a moderate drinker. Is moderate indulgence the equivalent of one, two, three, or four glasses of whisky per diem? Are we to take as the standard of moderation, the smallest or the largest quantity of alcohol daily consumed by any one of the signatories, or the mean of their respective total daily consumption? We need explicit information on this head. The term “moderate” is in truth a highly elastic one, possessing very different meanings for different individuals. I recently asked a casual acquaintance what he understood by moderate and he gave as answer “half a bottle of whisky a day.” And I told him that I was going to suggest two glasses, or...
their equivalent to which he replied that a man who limited himself to so small a quantity was to all intents and purposes a teetotaller!\(^4\)

Campbell went further to suggest that the failure to quantify moderate drinking was matched by a failure to stipulate which types of alcohol should be considered ‘moderate drinks’ that were beneficial to health. He believed that the quality and type of alcohol were key factors in determining its effects on human health. Campbell concluded that

> The mouthpiece of the British medical profession, would have you to understand that nine-tenths of you will be benefited in health by the moderate use of alcoholic beverages, but we leave it to you to decide what a moderate quantity is, and you may choose any kind of alcoholic drink your fancy prompts.\(^5\)

Doctors could not agree on ‘healthy’ amounts of alcohol consumption or if alcohol was beneficial in therapeutics. In a presidential address to The British Medical Association in 1905, Dr James Barr gave a speech on the use of alcohol as a therapeutic agent in which he argued that less alcohol was prescribed because of ‘fashion’ rather than from any scientific reasoning on its usefulness as a medicine.

> There is no other drug in the pharmacopeia that has such an accommodating action to circumstances. It would seem as if in any particular case we could never predicate as to whether alcohol is going to do good or harm. Surely some indications could be laid down for its use so that we should know beforehand what effect it is going to produce.\(^6\)

Barr called for more scientific research on the uses and effects of alcohol as a therapeutic drug because he believed that it remained useful in medicine and more importantly, despite the controversy over its use, many doctors still prescribed it anyway. To illustrate this point Barr set out the principal therapeutic uses of alcohol in treating a range of illnesses: In the treatment of pneumonia he personally recommended the use of a ‘light draught beer’ as a sedative and in typhoid fever a ‘pint of good bitter’ was given in small doses over twenty-four hours. Cases of vomiting were treated with small doses of champagne and brandy was administered in cases of collapse or shock. For palliative care, he noted that diluted brandy was often given freely in the last days of life and for
invalids it was common to prescribe ‘a good port’ during periods of convalescence. In the treatment of nervous diseases, alcohol was used as a sedative and an analgesic. Cases of neuralgia were treated with a ‘glass of good stout’ and for cases of angina, hot whisky or brandy were recommended. Barr described alcohol as a versatile drug that was available in a variety of forms that could be used to treat a range of illnesses. He believed that this made it a valuable medicine that should not be swept aside by fashion or moral concerns. Yet some doctors were critical of what they believed to be the morally questionable practice of prescribing alcohol. In 1885, Dr Norman Kerr, the prominent temperance campaigner and founder of the British Society for the Study of Inebriety, urged caution when prescribing any alcohol.

We can never forget that intoxicating drinks cannot be ordered without some risk of a taste for them being acquired, and the remedy itself proving worse than the original disease. This risk was exemplified in the case of a favourite dog of two maiden ladies of my acquaintance. This animal was seized with an attack of acute pneumonia. The veterinary surgeon gave the dog brandy; and the dog recovered, whether because of or in spite of the stimulant, I cannot tell. Ever since, if he hears anyone speak of brandy, he is up in a moment on his hind legs, begging for the seductive physic. Though I believe the cases of what may be called ‘medical drunkenness’ are not nearly as numerous as is popularly asserted, I have known instances where the medical prescription of strong drinks has been the beginning of a career of excess.

Kerr’s opinion was based on his belief that for some individuals (and dogs), alcohol was a dangerously addictive substance. He, therefore, believed that the continued use of alcohol in therapeutics could lead to an increase in cases of ‘medical drunkenness’ which could in turn damage the reputation of the profession. In a speech given two decades later to the Lancashire and Cheshire branch of the British Medical Profession, Dr Charles Macfie echoed Kerr’s views regarding the use of alcohol in medicine. Macfie believed that doctors had a duty to promote and support temperance reform, particularly when increasing scientific evidence and medical opinions suggested that alcohol was not conducive to good health. Like Kerr, he also believed that by continuing to prescribe alcohol, the medical profession risked damaging its reputation. Macfie gave the example of recent accusations by some temperance groups that
increasing amounts of inebriety were due to taking alcohol ‘under doctor’s orders’

This insinuation is a glaring economy of the truth and before such insinuations are published to the world, one would expect any fair minded society or individual to first probe the truth about ‘doctor’s orders.’ There are two sides to a ladder. No drunkard ever takes the blame for his or her degraded condition as the profession so well knows. According to them, their own family circle and nearest friends are their direst enemies; and how often has a chimerical ‘doctor’s order’ been given as an excuse! I could understand our being urgently requested to avoid prescribing alcohol in any form, on account of the moderate use of it becoming a habit and ultimately developing into a craving. The medical profession is as anxious that alcohol should not be abused and that human beings should not suffer in mind and body from its effects, as any teetotaller can possibly be.\textsuperscript{11}

Although he had reservations about the validity of the claims made by the temperance groups, Macfie remained concerned that prescribing alcohol could bring the profession into disrepute because a prescription to drink could be risky—not only in terms of ethics but also in the damage it might do to professional reputation. Yet others were concerned about the implications of reducing or stopping the use of alcohol in medicine. In an article in the \textit{British Medical Journal} in 1890, one doctor (who remained anonymous) highlighted the differences in alcohol use between workhouses and general hospitals

The general hospitals throughout the country have very materially reduced their expenditure on alcohol in all its forms, but the general hospitals have not abandoned its use \textit{in toto} … The class of cases in the union infirmaries [where no alcohol was prescribed] are exactly identical with those in the general hospitals. The workhouse medical officer has to treat pneumonia and other acute diseases and grave surgical operations are performed in many union hospitals. At the Leeds General Infirmary alcohol is used. Must we conclude that the staff of Leeds General Infirmary are wrong in continuing this agent\textsuperscript{12}

Evidently, this doctor was concerned that the welfare of patients was put at risk by a distinction based on moral rather than medical grounds. Alcohol still held value within therapeutics and in surgical procedures and therefore to deny it to patients within workhouse hospitals must
have seemed ethically questionable. However, temperance debates aside, by the early twentieth century there was growing scientific evidence for restricting the use of alcohol in medicine. Macfie referred to several studies that challenged the prevailing view that alcohol provided stimulation in cases of disease and debility.\textsuperscript{13} These studies showed that alcohol also had an irritant or depressive action on nerves and body tissues. Macfie also pointed out that there were alternatives to alcoholic stimulation in therapeutics.

In turning to our \textit{Pharmacopeia} and our \textit{Extra Pharmacopeia} for substitutes for alcohol, we are at once impressed with the fact that most drugs have more or less stimulant properties, either local or general, for example, phosphorus, arsenic and iron, chloroform and the ethers, and the various alkaloids – all stimulant in medicinal doses.\textsuperscript{14}

By the early twentieth century, there were pharmaceutical alternatives to alcohol that challenged its efficacy as a drug. Yet some doctors still believed that alcohol had an important place within therapeutics. In a speech given in 1909 to the Border Counties Branch of the British Medical Profession, Dr James MacDonald set out a convincing argument in favour of the continued, judicious use of alcohol in the treatment of illness and disease.\textsuperscript{15} He argued that advances in medical knowledge were not sufficient to dismiss the role of alcohol as a valuable medicine.

There are of course habits and fashions in therapeutics as in everything else. Fashions in the past have sometimes been regulated by the prevailing theory of the origin of disease. In the days, for example, when diseases were set down to inflammation, bloodletting was all the vogue, and the use of alcohol was looked on as a perilous enormity. Then came the period when our bodily ills were ascribed to lowered vitality, and the stimulants were administered to therapeutic excess. At the present day, the bacterial origin of disease does not materially affect the employment of alcohol, which is generally given with judgment and discretion.\textsuperscript{16}

In other words, the advent of germ theory did not radically change the role of alcohol in therapeutics. MacDonald believed that increased knowledge of the aetiology of disease meant that alcohol was prescribed more accurately and only when absolutely necessary. He argued that this change was not enough for the medical advocates of temperance reform who warned the profession to stop prescribing alcohol or face ‘the high
road to therapeutic nihilism. Which meant that by continuing to prescribe alcohol the medical profession risked doing more harm than good. MacDonald questioned the professional integrity of medical men who put their ‘extreme’ personal beliefs about temperance above their duty to patients. He cited an article published in *The Lancet* in 1908 written by a group of ‘well-known medical experts’ who expressed the view that alcohol was a ‘rapid and trustworthy restorative’ that in some cases could be a ‘life saving drug.’ MacDonald believed that the majority of doctors shared these views.

The manifesto discharges a kindly service as a protest against the uncompromising opposition of a body of extremists to the rational use of alcohol. It does more – it applies a spur to the indifference displayed by many medical men with regard to an eminently practical question. It is true that on minor points a divergence of opinion exists, but on fundamental principles there is common agreement.

This ‘common agreement’ was evident in hospital records which show that up until the First World War alcohol was still used in large urban voluntary hospitals and asylums. Although its use may have courted controversy among medical men and temperance organisations, the continued use of alcohol indicates that it was still widely regarded as a reliable therapeutic drug. There were very few prescription drugs that offered the same degree of versatility to treat fevers, disease, debility and provide a degree of comfort for patients during the course of illness. Alcohol was the rational drug of choice because it was relatively cheap, widely available and came in a variety of different forms that suited the needs of a wide range of patients.

**Alcohol Use in Hospitals and Asylums**

The value of alcohol was evident in hospital records which show that various types of alcoholic drinks were used in the treatment of patients suffering from a range of psychological and physiological conditions. The records of four Glasgow hospitals show that between 1870 and 1914, alcohol was still used in the treatment of patients. During this period, Glasgow was one of the largest industrial cities in Britain and rapid population growth meant increasing problems associated with ill health and disease. The city therefore makes a good case study for the therapeutic
use of alcohol in the treatment of illness. The records of Glasgow Royal Infirmary; Gartnavel Royal Lunatic Asylum; The Western Infirmary and Hawkhead Asylum show increasing numbers of admissions in the late Victorian and Edwardian periods. Hospital expenditure on alcohol sometimes correlated with the number of admissions either increasing or decreasing according to the numbers of patients admitted and treated. Yet as the graphs show, between 1875 and 1914 there was a general trend towards growing numbers of admissions and decreasing expenditure on alcohol (Graph 9.1).

The graph shows that until 1895 alcohol use fluctuated. In 1891 there was a sharp increase in expenditure on alcohol but it is unclear from the records why more was spent in that year. It could be that particular types of admissions required treatment with alcohol. According to the 1891 records of the Registrar General for Scotland the highest numbers of deaths in Glasgow in that year were from bronchitis and pneumonia, which were predominantly secondary infections. The highest numbers of deaths from contagious diseases in 1891 related to measles, whooping cough and phthisis (tuberculosis). It may be that these types of illnesses required therapeutic treatment with alcoholic stimulants. The
Graph 9.2  Gartnavel Royal Asylum alcohol expenditure from 1875 to 1885. The dates shown are those in which alcohol expenditure was listed in the annual reports.

The data from the Western Infirmary shows a negative correlation between increasing numbers of admissions from 1895 onwards and decreasing expenditure on alcohol. By 1905, alcohol expenditure had fallen significantly despite a sharp increase in admissions in the same year. This is a similar pattern to that found in Glasgow Royal Infirmary and may be indicative of the financial constraints posed by larger numbers of admissions. This contrasts with the data shown below from a smaller institution, Hawkhead asylum where expenditure on alcohol remained fairly consistent until 1912 when it began to decline (Graph 9.4).
Graph 9.3  Western Infirmary alcohol expenditure from 1880 to 1905. The dates were selected at five-year intervals\textsuperscript{24}

Graph 9.4  Alcohol expenditure in Hawkhead Asylum 1907–1913. The dates shown are those in which expenditure on alcohol was listed in the annual reports\textsuperscript{25}
The data from the Glasgow hospitals suggests that overall expenditure on alcohol varied across different types of institutions and changed over time. It also shows a general trend towards restricting expenditure on alcohol. It is however difficult to ascertain exactly how the alcohol purchased was used in the treatment of patients and why this changed over time. In each of the institutions, the ward casebooks and patient notes lacked detailed information on treatment regimes and more specifically, on any alcohol prescribed. There was a case in Gartnavel Royal Asylum of a male patient admitted in 1888 suffering from ‘low mood’ exacerbated by bronchitis, who was prescribed 4 grams of whisky daily plus an expectorant mixture. In the annual report for 1871, the medical superintendent of Gartnavel discussed the use of alcohol and stated that there were a number of weak, helpless bed-rid patients, especially in the East House, suffering from various diseases of long standing, many of whom were organically affected on admission... While all the patients require to be well nourished and supported and are so, these patients, in consequence of their greater want of vitality, often require food to be expressly prepared for them and with stimulants to be administered both night and day with a large amount of kind and considerate treatment.

It would therefore appear that alcohol played an important role in the treatment of chronic diseases and palliative care. In another Scottish asylum, The Chrichton Royal, alcohol was sometimes used in the treatment of private patients—even those with existing alcohol problems. One patient admitted in 1886 suffering from eccentric and delusional behaviour was allowed generous amounts of alcohol. His case notes stated that Mr H has resided at Kirkmichael House all winter and has had shooting all the season. He has been fairly contented as long as he had unlimited meal and drink. His appetite was enormous and at a meal he has been known to eat a leg of mutton with the usual accessories...and finish off with half a dozen eggs...he has been allowed three glasses of whisky daily and as much beer as he chose to drink. He usually took the whisky undiluted.

This case highlights the differences in treatment with alcohol among private and pauper patients. Even if viewed as a necessary therapeutic agent, alcohol was an additional expense in the course of treatment and perhaps one that hospitals with larger numbers of pauper patients could ill afford.
In addition to the asylums, alcohol was also used in the treatment of infectious diseases in Belvedere (fever) Hospital in Glasgow. In the 1866 annual report the medical superintendent of Belvedere noted that during the typhus epidemic of 1861 and 1862, the hospital admitted 1837 patients and of these, 1289 were typhus cases. The alcohol consumed during this period was: 62,754 ounces of wine, 8440 ounces of whisky and 2611 ounces of brandy. The Medical Superintendent, Dr Russell believed that it was important to weigh up the therapeutic benefits of ‘alcoholic stimulation’ with the economic considerations. He stated that during the typhus epidemic, Belvedere Hospital and Glasgow Royal Infirmary had admitted similar numbers of typhus cases and that both hospitals had used alcohol in the treatment of patients. Yet Belvedere had successfully treated patients with a more judicious use of alcoholic stimulants than the Royal Infirmary. In fact, Dr Russell claimed that there were fewer deaths from typhus in Belvedere than in the Royal Infirmary and that the average length of stay was considerably less in the former.

The use of alcohol in treating fevers and other illnesses was reported in medical journals. Aside from the financial implications of alcohol use, some doctors believed that it only held therapeutic value in certain cases and in particular stages of illness and disease. In an article in the *British Medical Journal* in 1880, Dr H. McNaughton a physician in The Fever Hospital Cork, provided evidence to support his claim that alcohol should be prescribed carefully in fever cases. He kept records of his patients from January 1873 to June 1879, a period in which he treated 889 fever cases mainly typhus, typhoid and simple fever. On average 30% of patients were treated with alcohol during this period. Most fever cases were treated using brandy, claret and wine. He provided a patient case study of a girl he described as being one of the worst cases of typhoid fever he had ever treated. In the early stages of her illness he prescribed no alcohol but instead treated her using milk, beef extract, foulbroth, digitalis, ipecacuanha (an expectorant sometimes used to treat dysentery), Dover’s Powders, quinine and opium. In the later stages of illness, he prescribed a mixture of brandy and milk every four hours and one ounce of claret every two hours. The girl recovered completely.

The type of alcohol used in the treatment of illness and disease varied. This was reflected in the Glasgow hospital data. The most popular types of alcohol purchased during the 1870–1914 period were wines and champagne, brandy, whisky, porter and beer. Most hospitals held
accounts with local wine and spirit merchants and the Royal Infirmary bought alcohol from two Glasgow firms: Samuel Dow and Thomas Anderson. The quantities and types of drinks purchased changed from year to year, sometimes reflecting the numbers of patients treated but at other times it seemed that certain drinks became more popular or fell out of use. Graph 9.5 shows the changing types and quantities of alcohol purchased by Glasgow Royal Infirmary over a 30-year period.

Certain types of drinks like porter and port wine remained popular over the 30-year period. Sherry fell out of use but champagne and claret were in more demand towards the end of the century. Coleman’s Wincarnis Tonic Wine was purchased for the first time in 1891 with a sizeable order totalling £61 3s 12d, which in today’s money equates to an annual spend of around £3665 on tonic wine. The data from the Glasgow hospitals suggests that between 1870 and 1914, the types of alcohol purchased by hospitals changed, and that although there was an overall trend towards spending less on alcohol, its usage continued.

As many doctors still prescribed alcohol, it fell to the medical profession to investigate its role in the treatment of illness and disease.
Between 1880 and 1914 there were articles in *The British Medical Journal* and *The Lancet* that investigated the use of alcohol in medical practice. Some of these articles provided chemical analyses of various alcoholic drinks because it was considered important that doctors were informed of the best types and quality of wines and spirits to prescribe to patients. Following the reduction in duties on imported wines from France, two articles appeared in *The Lancet* in June and July 1880. The articles were titled ‘The Lancet Commission on the Medical Use of Wines’ and each instalment dealt with different varieties of French wines. The first article in June 1880 stated:

> We cannot believe that any wines whatever are necessary for a healthy adult in good physical strength, taking a fair amount of daily exercise and with no excessive mental strain. Most light wines taken sparingly with meals do no harm to a person under the same conditions and are quite as consistent as the consumption of tea, coffee etc. which generally take their place. Indeed, strong tea, strong coffee and (we would add strong tobacco) have much to answer for in the production of indigestion and nervous palpitation … To the invalid, the wines are frequently of great value and in some of the acute fevers the most powerful alcoholic beverages have sometimes to be prescribed … [However] the patient’s daily question “what shall I drink?” requires more consideration than is usually devoted to it before the medical advisor gives the stereotyped reply “Oh you can take a little claret”.37

Both articles aimed to educate doctors on the composition and therapeutic value of various types of French wines. This was achieved by providing chemical analyses of the four basic constituents of wines, namely alcohol, sugar, acid and tannin. The articles claimed that differing levels of each of these constituents not only altered the taste and quality of the wine but also its therapeutic value.38 In the case of claret it was noted that there were huge differences in the quality and chemical composition of this particular type of wine but it was still believed to have medicinal applications.

> In cases of anaemia, ordinary debility from overwork, feeble digestion etc., a sound red claret is almost as good a prescription as most of the tonic drugs in the Pharmacopeia and is always an advantageous adjunct to this class of remedies. Of course, it must only be taken with the meals and in
no case should more than half a bottle be permitted with the meal. In this quantity, the amount of alcohol is very small.39

Although the articles aimed to give a scientific analysis of the therapeutic value of wine, each instalment also provided information on sourcing the best vintages and brands. For example, an analysis of white Bordeaux wines used ‘an excellent Sauterne 1870 from The Cafe Royale’ to highlight the therapeutic qualities of that particular type of wine.40 Another article in *The Lancet* in 1894 looked at the medical value of ‘tonic’ champagnes such as Laurent-Perrier Grand Vin Brut Champagne Sans Sucre and Coca Tonic Champagne Sans Sucre which were recommended for use in treating diabetic patients. Chemical analyses of both drinks concluded that they were palatable and of a similar quality to other ‘high class’ champagnes.41 Although there was no medical consensus on the therapeutic value of alcohol as a generic drug there did seem to be some agreement that if alcohol were to be used, it should be of the best quality and type. This is hardly surprising, given that most doctors were middle-class men and many of their fee-paying patients were also middle and upper class. The range of illnesses that were financially treatable with a ‘sound claret’, coca champagne or a good quality brandy were therefore likely to be middle or upper-class illnesses such as fatigue, neurasthenia, exhaustion from overwork and digestive complaints. In this sense, doctors were only prescribing the types of alcoholic drinks that their patients would normally drink anyway, so in effect it was a prescription to drink well.

The financial aspect of prescribing alcohol was perhaps more of a concern for public hospitals and asylums that had to justify expenditure on the poorer working classes. The Glasgow hospital and asylum records show a general decrease in spending on alcohol during a period when it’s continued use within medicine courted controversy. Although some doctors wanted to distance the profession from the moral taint of intemperance, many were prepared to carry on prescribing alcohol because they had faith in its therapeutic value. One important point to consider is that alcohol was still being bought and used within hospitals and this suggests a lack of viable alternatives at that time. In other words, doctors simply had no other choice but to prescribe alcohol and perhaps the real pressure was to do so judiciously. This could certainly account for the decrease in the use of alcohol in the decades leading up to the First World War.
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