Medical History, 1985, **29**: 210–217.

Essay Review

TERRY M. PARSSINEN, *Secret passions, secret remedies. Narcotic drugs in British society 1820–1930,* Philadelphia, Institute for the Study of Human Issues; Manchester University Press, 1983, 8vo, pp. xiv, 243, illus., £21.00.

DAVID COURTWRIGHT, *Dark paradise: opiate addiction in America before 1940,* Cambridge, Mass., and London, Harvard University Press, 1982, 8vo, pp. x, 270, £16.00.

H. WAYNE MORGAN, *Drugs in America. A social history, 1800–1980,* Syracuse University Press, 1981, 8vo, pp. xi, 233, illus., $20.00.

Drugs, opium in particular, have undergone a historical metamorphosis in the past few years. What once passed for the "history of opium" were some scattered references to Homer and nepenthe, Shakespeare and "drowsy mandragora", with the Chinese opium wars thrown in for good measure. There were no studies of drug use and the development of control policy in either Britain or the USA. Issues such as the introduction of hypodermic morphine and the establishment of disease views of addiction were seen simply as matters of medicine and technology, as harbingers of some contemporary understanding. The inadequacy of these approaches as the basis for an understanding of the relationship of opium and other drugs to society has been demonstrated, and is further underlined by Terry Parssinen's book on narcotic drugs in British society.

Dr Parssinen covers the changes in the status of opium, both in society as a whole and in social policy, in the period 1820–1930. His survey moves from the open sale of opium at the beginning of the nineteenth century to the beginnings of public health concern, the advent of hypodermic morphine, and the establishment of drug control policy in the early years of the twentieth century, culminating in the 1926 Rolleston Report. This Report confirmed what became known as the "British System" of drug control, a medically based control policy often contrasted with the penal policy established in the USA at the same time, to the detriment of the latter. I found two sections of particular interest. Dr Parssinen surveys the extensive involvement of British morphine manufacturers in illegal morphine smuggling in the Far East in the first decades of the twentieth century. Britain was, for much of this period, the world's major manufacturer of the drug. The decline and ending of the Indo-Chinese opium trade in the early 1900s was replaced by a considerable increase in the export of morphine to China, much of it smuggled via Japan. The extent of this trade, illegal since the 1909 Mackay Treaty had prohibited the import of morphine into China, was revealed by the almost universal introduction of an import/export certificate system after the passage of the Dangerous Drugs Act in Britain in 1920. The Humphrey case in 1923 indicated the continued involvement of one British manufacturer, T. Whiffen and Son, which thereby lost its licence to manufacture and export morphine and cocaine. Britain thereafter, through the influence of Sir Malcolm Delevingne of the Home Office at the League of Nations, became the leading advocate of international narcotics control.

Dr Parssinen, in a chapter on illicit drug use in the 1920s, also analyses prosecutions under the Dangerous Drugs Act in order to build up an "addict profile" for the 1920s. The limited number of cases—never more than two or three hundred a year—indicated that there were three distinct drug-taking populations—opium-smoking Chinese, the cocaine subculture using the drug recreationally and an older (and smaller) group of morphine addicts often with some medical connexion. These are much the same types of grouping indicated by evidence presented to the Rolleston Committee in the '20s.

The book is readable and lucid; the narrative moves at a pace and there is an afterword comparing the differing development of drug use and drug control in Britain and America, which will be of particular interest to an American readership. The overall time frame of the book, together with this afterword, means that there is much to deal with, and this has led to certain problems. I found myself wishing at many points for a greater depth of analysis and information, but also for the exclusion of other material which was not directly relevant. To

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give some examples—the discussion of the import and distribution of opium rightly notes the importance of Turkish opium on the British market throughout the nineteenth century. Persian and Egyptian opium only came into Britain in any quantity in the 1870s and '80s and even then did not rival opium from Turkey. But the detailed discussion of the organization of the drug trade in London's Mincing Lane seems out of place when that evidence—given to the Select Committee on Adulteration of the 1850s, for example—indicates that there were separate arrangements for opium, which was often sold by private arrangement rather than by public auction with the other drugs.[1]

Opium's place in medical practice and in self-medication has a somewhat hurried treatment; Parssinen includes a discussion of the herbal and botanic medicine traditions when, as he notes, opium in fact figured very little in this literature. He appears not to have used to any great extent the manuals of domestic medicine or chemists' prescription and day books. It is to these that one must turn for evidence of the everyday normality of over-the-counter sales of the drug. Records of the small, non-pharmaceutical shops selling opium freely before the 1868 Pharmacy Act have unfortunately not survived, if they ever existed. The passing of the 1868 Act too, which restricted the sale of opiates (apart from patent medicines containing the drug) to professionally qualified pharmacuetical chemists, is perfunctory. The inter-professional wranglings between the rival pharmaceutical organizations and between these and the medical profession, those members who were involved in public health in particular, over the type of overall restrictions to be imposed, provide an apt demonstration of professional interest in opium restriction which Dr Parssinen is concerned to stress elsewhere.

The transformation of what had been known as opium-taking into the disease of opium inebriety, morphinism, or morphinomania—a variety of terms were in use—is discussed; Dr Parssinen relates the emergence of the concept to the hypodermic use of morphine and to the particular situation of the medical profession, in terms of the interaction between doctors and morphine-using patients and the increasing self-confidence of the profession by the last quarter of the nineteenth century in its capacity to deal with disease. This line of argument could be broadened beyond its professional confines into a consideration of the social function of disease theory. The addict's "disease" appeared often to lie in the breaking of social norms of behaviour, and discussion of treatment concentrated on the re-education of the will and questions of self-control. There is now a considerable literature on this question of the social constitution of disease in many areas of medicine; it could have given the discussion of addiction as a disease greater depth if this type of approach had also been considered.[2]

The book pays considerable attention to the literary treatment of opium—discussing, for example, in a chapter entitled 'The palace of evil', Charles Dickens's *The mystery of Edwin Drood,* Wilde's *Dorian Gray,* and a Sherlock Holmes opium den story. But this material is generally not integrated very successfully into the main body of the text. The literary opium den material is placed awkwardly between discussions of child-doping and the public health crusade on opium. It would appear more relevant to the sections of the book covering the later nineteenth century, particularly Chapter 8 on the Chinese and opium. Literary material appears in this chapter too, and in the analysis of disease theory in Chapter 7. Parssinen makes claims for it that are difficult to sustain. He maintains, for example, that the disease theory of drug addiction was translated almost wholesale into popular literature and that "the image of the drug user was transformed accordingly". Yet the overriding impression from newspapers and literature of the second decade of the twentieth century is that the image of the drug-taker remained a resolutely moral one with drug-taking perceived as a vice rather than an illness. During the Billie Carleton case of 1918–19, for instance, newspaper reports almost without exception presented drug-taking in this way. The opium habit was "a vice, scarcely less than alcoholic drunkenness". "Perhaps the most expensive of vices . . . moral forces and even

[1] PP. 1854–5, VIII, *First Report from the Select Committee on the Adulteration of Food, Drink and Drugs.*

[2] For example, K. Figlio, 'Chlorosis and chronic disease in nineteenth century Britain: the social constitution of somatic illness in a capitalist society', *Social History,* 1978, **3**: 167–197.

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family ties count as nothing", "a vice of the neurotic, not a habit of the normal"[3] (some groping towards a medical formulation here). By no stretch of the imagination could popular literature and the media in this period be said to be presenting a disease view of addiction. Parssinen himself notes this when, in his discussion of the 1926 Rolleston Report, he underlines a disparity between the nature of addiction as perceived by the media and that seen by the medical profession.

The attitude to the media image of drug-taking is in fact contradictory. On the one hand, Parssinen claims popular literature saw it as a disease; on the other, that media images reinforced the hard-line approach of the 1920s, i.e., reinforced a penal rather than a medical approach. Neither view is sustainable. Popular literature did not, in general, view drug-taking as a disease, and it is debatable what influence media representations had on public opinion. The book claims "what most people knew about the effects of cocaine or opium, or about the traffic in drugs, they knew from the morning newspaper, the latest Sax Rohmer thriller, or the film showing at the local cinema. Regardless of their accuracy, these media depictions were of great importance in shaping the public image of narcotic drugs" (pp. 125–126). Most research on "media effect", however, indicates that public attitudes are not shaped in such a simple or direct way; and this concentration on literary source material ignores the wider range of evidence—from oral testimony, newspaper correspondence, and letters in the medical and pharmaceutical journals—which saw it as nothing much to worry about, a relatively harmless predeliction of a few elderly ladies or the domestic custom of sea-faring Chinese. Public attitudes towards cocaine, a drug with few popular uses, were always harsher; but the discussion of the media interpretation of drugs needs to be sensitive to the diversity of opinion that existed.

The discussion of working-class opiate use could also be more aware of social context. Parssinen accepts without much dissension the stereotype presented in parliamentary papers by outside observers of infants dosed with opiates by careless child-minders while the mothers were at work. This is now recognized to have little foundation as a generalization. Professional child-minders cared for only a minute proportion of children in factory areas; most women with young babies did not go out to work, or did not work in the way represented in the parliamentary inquiries on which the study has relied. Over one-third of working women in Preston in the 1850s, for example, were in non-factory occupations, while others worked irregularly or part-time.[4] The opium-doping child-minder should be discarded as a general stereotype. Mothers, whether working or not, were certainly likely to use opiates, with undoubtedly deleterious effects. But were opiates cause as well as effect? Parssinen comments, "not surprisingly, children who were fed opiates were often in desperately bad health" (p. 44). This statement, I feel, could easily be turned on its head. Children were in poor health anyway—and so were fed opium to keep them quiet. The context of poor living conditions, long hours of work, child ill health, is subordinated to a drug-centred approach here. The cultural importance of opium in working-class child-rearing practice is also ignored. The evidence of a twenty-year-old Nottingham lace-worker to the Childrens' Employment Commission in 1842 is cited, but there is no comment on one interesting passage. ". . . when the infant was four months old it was so 'wankle' and thin that folk persuaded her to give it laudanum to bring it on, as it did other children. . ." (p. 44). Opium was not just a knockout drug; there appears also to have been popular belief in its positive powers.[5] One could perhaps relate this to older medical perceptions of opium as a "stimulant".

Well-established stereotypes of opiate use for working-class infants are emphasized, but the book plays down the public health concern for adult opiate use. Contemporary analyses of narcotic addiction and abuse recognize that who is using a drug is as important a stimulant of public concern as the objective effects of the drug itself. Unemployed youths using heroin in

[3] See *Daily Express,* 24 December 1918: 9 December 1918; *Daily Mail,* 16 December 1918; *Evening News,* 14 December 1918; *The Times,* 21 December 1918.

[4] M. Anderson, *Family structure in nineteenth-century Lancashire,* Cambridge University Press, 1971, pp. 71–72.

[5] See also my discussion of this in V. Berridge and G. Edwards, *Opium and the people. Opiate use in nineteenth-century England,* London, Allen Lane, 1981, p. 102.

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the 1980s are seen as a "problem"; middle-class morphine injectors in the 1920s were generally not, The undercurrent of concern about working-class opiate use which ran through many of the standard public health inquiries of the period from the 1820s to the 1850s, and those in the same period into the sale of poisons, was never a major public health concern, but it should not be denied. Some of these observers sought evidence for, or stressed the "luxurious" or "stimulant" use of opium by working-class adults, when what they appear to have been describing was ordinary working-class self-medication with opium which could, on occasion, shade into habituation with long continued use. Parssinen comments on the rarity of intoxicant use by working-class adults—he, like the contemporary observers, misses the point that, while conscious intoxication was rare, what would now be termed addiction or dependence must have been widespread. This only became obvious when, for some reason, supplies were curtailed. After the passing of the 1868 Pharmacy Act, for instance, Dr Thomas Joyce of Rolvenden in Kent, noticed a number of cases of "opium sickness and purging" in his village. Dr Francis Anstie, editor of the *Practitioner,* found similarly from his experience in London hospitals.[6]

Dependence on this scale was to be expected when enough opium was being imported in considerable quantities. Dr Parssinen spends some time discussing opium import/export data and has recently criticized what he sees as my argument on the same question, which was presented in *Opium and the people* and elaborated elsewhere.[7] In reality, there is little to disagree about, and the criticisms seem to rest on a misunderstanding of my position. According to Parssinen, I argue that it is possible to derive definite consumption figures and trends from opium import/export data post 1860, when duty on opium was removed and home consumption figures disappear from the published statistics. My argument, as he sees it, is that trends in home consumption after 1860 (derived by subtracting imports from exports for each year) showed wild actual variation and that an apparent decline in home consumption was related in some way to the economic misfortune of purchasers and consumers of the drug, and that the production of morphine for domestic use was also involved. What I did say was quite different. I compared published home consumption figures prior to 1860, calculated per 1,000 population, with estimated figures derived by a simple subtraction of exports from imports on a yearly basis, *(Opium and the people,* p. 309). This, even when both sets of statistics were averaged out on a five-year basis (ibid., fig. 3, p. 35), provided a very imperfect method of assessing trends in consumption, for the "actual" and "estimated" graphs bore only a general relation. Trends derived on this basis post 1860, when only the estimated figures are available, have therefore to be treated with caution, in particular since the evidence of mortality rates is at variance. Certainly, the absolute yearly amounts have no validity at all as indicators of home consumption. The estimated home consumption figures are also complicated by the growth of the morphine industry. The growth of the British morphine industry stimulated the increase in opium imports and hence in estimated home consumption after 1860. My stress on domestic morphine referred to morphine production, not consumption. I suggested that a possible decline in home consumption (based on the very imperfect estimated home consumption figures) could be connected, not with actual home consumption but with the economic "Great Depression" and the fortunes of the morphine industry. Less morphine was being manufactured and exported because of the business cycle, consequently less opium was being imported and the estimated home consumption trend was in decline. There was certainly no connexion with the "economic misfortune" of domestic consumers; the Great Depression was in any case a time of rising real wages and improvements in standards of living. Morphine produced for export complicates any interpretation of estimated home consumption figures. I nowhere assume that morphine was "largely consumed domestically" as Parssinen states—quite the opposite, in fact. Directly after my discussion on import/export statistics post 1860, I

[6] T. Joyce, 'The Pharmacy Act and opium eaters', *Lancet,* 1869, **i:** 150; F. E. Anstie, *Stimulants and narcotics,* London, Macmillan, 1864, p. 149.

[7] See T. Parssinen's essay review of Berridge and Edwards, op. cit. note 5 above, *Med. Hist.,* 1982, **26:** 458–463. Berridge, ibid., pp. 35, 146, and 309; V. Berridge and N. Rawson, 'Opiate use and legislative control: a nineteenth-century case study', *Social Science and Medicine,* 1979, **13A:** 351–363.

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make it clear that morphine was never that important medically and certainly not in popular usage at this period.

There is little to disagree on here. When I would differ more substantially is over the interpretation of the period 1900–30 and the conceptual framework of the book as a whole. The concentration on literary and media material on drugs means that drug control policy in this period, and in particular the 1920 Dangerous Drugs Act, is presented as primarily the outcome of concerned public opinion—"the sense of menace posed by narcotic drugs created a widespread feeling that 'something must be done' "(p. 126). This is true to some extent, but the Foreign Office papers for this period, which are not used in this study, also make it clear that control was the result of a good deal of international manoeuvring and that the international implications of control, as much as domestic developments, influenced policy-makers in 1918–20. The 1920 Dangerous Drugs Act was, in fact, put on the statute book because article 295 of the Versailles peace settlement, at British insistence, ensured the universal application of the Hague Convention of 1912. This 1912 Convention, which envisaged a world-wide system of narcotics control encompassing morphine and cocaine as well as opium, had its origins in the Shanghai Commission of 1909, which sought to control opium only in the Far East. Britain had been reluctant to join in the American-dominated Shanghai discussions, primarily because the Indo-Chinese opium trade was already being brought to an end and Foreign Office officials were averse to international "interference" in what was seen as a matter between England, India, and China. But Britain's attitude underwent a change by the time the Hague Conference met in 1911. It was at British and German insistence that morphine and cocaine were included and the confinement to "legitimate medical purposes" inserted; this set the pattern of international control on a world-wide rather than Far Eastern basis. The apparent British volte-face was in part a diversionary tactic to delay the meeting at the Hague, but in part—as correspondence with the India and Colonial Offices indicates—arose out of genuine concern for the growth of morphine and cocaine smuggling in the Far East.[8] The application of the 1912 Convention after the First World War and the consequent passage into law of the Dangerous Drugs Act owed surprisingly little to the domestic drug scene. Even within the Home Office, it was only mentioned in passing. What appeared to concern the Home Office, which was pressing for immediate action, and the Foreign Office more, was the international drug trade, morphine and cocaine smuggling in particular. A Home Office memorandum to the Foreign Office in November 1918 stated; " . . . the disadvantage of the Convention being only partially operative need not now be regarded as a sufficient reason for not attempting to make it operative as far as possible . . . complete security against illegitimate trade can never be hoped for; even if all the states adhered, their standards of enforcement would vary wildly."[9] The international dimension was important in domestic drug control policy; it is a pity that a book which discusses morphine smuggling in detail does not emphasize this.

The analysis of the genesis of drug control policy itself over the period 1916–26 tends to be perfunctory at certain points. The book, for example, does not mention the conclusions of the committee on the use of cocaine in dentistry of 1917, which claimed that the cocaine habit was very limited. In discussion of the membership of the Rolleston Committee (p. 187) the connexion of Sir William Willcox with the Home Office (he was Home Office analyst) is not mentioned—Parssinen states that Dr Branthwaite of the Board of Control was the only representative from the Home Office. The already stated views of W. E. Dixon, Reader in Pharmacology at Cambridge and a member of the Committee, are also not mentioned. Dixon had written to *The Times* in 1923 stating clear opposition to any attempt to impose a penal policy on the US model and advocating a disease model of addiction. This is of considerable significance, considering the eventual conclusions the committee came to in its report and its focus on a "disease" and medically based view of addiction rather than a criminal one. Parssinen presents the 1926 report of the Rolleston Committee as a medical victory in a penal

[8] See, for example, FO. 371/847. Minutes of proceedings of interdepartmental committee on US proposal for an opium conference at the Hague, 12 July 1910.

[9] FO. 371/3176.

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versus medical struggle over the previous six years, the final defeat of the attempt to import US-style drug policy. "Not only did medical men beat back the proposed challenge to their professional autonomy, but in a more subtle yet important way they triumphed by imposing on the Report both the medical definition and the medical solution to the problem of drug addiction"(p. 196). This is the interpretation presented in most liberal US analyses of British drug policy.[10] Yet, as Parssinen himself acknowledges in his later comparison of drug use in Britain and America, "the differences between the [American]criminal model and the [British] medical model of drug addiction have been over emphasized." Both "systems" had an undoubted penal emphasis in terms of close control provided for the manufacture and sale of narcotic drugs and penalties for trafficking and recreational drug use. The only real difference was the provision for medical opiate maintenance in Britain but not in America. But this line of argument is not elaborated in the discussion of Rolleston.

As I have argued elsewhere, the period 1920–26 should be seen more as one of accommodation between rival professional and bureaucratic élites rather than conflict between "penal" and "medical" absolutes.[11] The medical profession were not necessarily defenders of a liberal ideology of drug control; the prison medical officers who met a different clientele of drug users took a distinctly harsher line in evidence to Rolleston. Neither was the Home Office a resolute defender of penal methods and opposed to medical control. As early as 1920, it was becoming obvious that the profession could not be excluded from the formation of policy. The profession by its opposition to regulations issued in 1921 and 1922 under the 1920 Act and by modification of the 1923 Dangerous Drugs (Amendment) Act, had obtained influence in deciding policy, and the Home Office itself recognized this medical role. The detailed negotiations that led to the setting up of Rolleston in 1924 make it clear that the Home Office would indeed originally have preferred an absolute line of abrupt withdrawal and the end of maintenance prescribing, but that there was also genuine Home Office concern about what was legitimate practice. Sir Malcolm Delevingne at the Home Office, despite wishing to control the profession, nevertheless had to turn to it to validate control. The doctors' right to decide at least part of drug control policy was thereby confirmed. Doctors, too, were no longer professionally autonomous in the way that is implied by the usual penal-medical dichotomy. The Home Office, for instance, relied on the Ministry of Health's Regional Medical Officers in dealing with doctor addict cases in the early 1920s; and doctor civil servants in the Ministry of Health had considerable influence on the formation of policy. Dr E. W. Adams, a staff Medical Officer, drew up in February 1923 a memorandum on treatment and maintenance which in many respects foreshadowed the conclusions of the Rolleston Committee of which he was later secretary. All this indicates that the evolution of drug control in this period was a more subtle matter than indicated by positing the medical profession and the Home Office as opposites, with the "British System" an idealized medical system of care.

The approach adopted as an interpretation of Rolleston here derives from the conceptual framework of the book. It was written as a contribution to the debate as to whether the US should adopt the British model of drug control. Dr Parssinen points out, as most commentators would probably now agree, that British medical control policies were a result and not a cause of the low numbers of addicts. The British reaction to drug addiction was a relaxed one simply because most addicts were middle class and there were not very many of them. His conclusions on the implications for US drug control policy are sensible. One cannot, he concludes, use Britain in the 1920s as a model for heroin maintenance in the US in the 1980s. But this "political" focus of the research constantly limits the range and complexity of the questions asked here. It has even dictated the time frame of the book; the period 1820–1930 is primarily a significant entity to those concerned with contemporary drug policy. Dr Parssinen's conclusions will certainly be of interest to those involved in policy-making in

[10] E. M. Schur, *Narcotic addiction in Britain and America. The impact of public policy,* London, Tavistock, 1963.

[11] V. Berridge, 'The making of the Rolleston Report, 1908–1926', *Journal of Drug Issues,* 1980, pp. 7–28; V. Berridge, 'Drugs and social policy: the establishment of drug control in Britain, 1900–1930', *Br. J. Addiction,* 1984, **79:** 17–29.

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the US, but his analysis is disappointing to a social historian or a student of social policy.

This is far from arguing that history should simply concentrate on debates of interest within the profession and that it should not concern itself with the contemporary implications of such arguments—that it should not be "relevant". Historical perspectives are used increasingly by today's policy-makers, nowhere more so than in the field of health and health care, and it is incumbent on historians to relate their expertise to the contemporary issues.[12] However, to adopt a research perspective directly focused on present-day problems so that research and writing is informed primarily by such issues seems to represent a probable narrowing, not a broadening of approach. It means that the analysis is informed by present-day priorities rather than by the very different perspectives of the past. It could result in nothing more than an updated version of the "march of progress" version of medical history, which social historians of medicine have rightly criticized. In the case of the history of drug control policy, a move away from the US-based policy focus would make possible some discussion of the deeper issues involved.

The changes in drug control policy in the United States over the past two decades have also been directly related to the "lesson of history". Historical studies of policy development in the USA, and particular perceptions of the past, have been used as arguments in the shaping of present-day policies. The history of US drug control policy has been the prototype "relevant history". The Harrison Narcotics Act of 1914, and legal decisions made under the Act, were criticized for introducing a penal system of control, whereby opiate addicts could no longer obtain maintenance doses of their drugs from doctors, and had to turn to the underworld for sources of supply. This, so the argument ran, criminalized sources of supply and vastly increased the number of addicts, who were no longer under medical control. It resulted also in a change of type and class of addict, from middle-class and respectable to lower-class and criminal. Contrasts were made with what was seen as the medically based "British system" of drug control introduced in the 1920s, which appeared to have resulted in a non-criminal middle-class addict clientele. Liberalization of drug control in the US, the introduction of methadone maintenance programmes in the 1960s and '70s, and the insertion of disease views of addiction into a criminally-based control system found support in this type of historical argument.

"Relevant history" has its dangers, however, not least that it often conforms too closely to the preconceptions of contemporary policy-makers rather than the very different perspectives of the past. In the less liberal '80s, perceptions have changed. The liberal view of the "British system" has already been challenged. Now, David Courtwright has produced a study of opiate addiction in the United States which undermines some of the force of the Harrison Act argument. The nature and type of addiction and addict were, he argues, changing well before 1914. Addiction, high throughout much of the nineteenth century, peaked in the 1890s and thereafter fell into decline. The characteristic iatrogenic opium or morphine addict of the nineteenth century, a white middle-class female, was already giving place to lower-class urban males, using heroin or cocaine, often with some criminal connexion. The Harrison Act did no more than accelerate a tendency already well under way; it cannot be used as a simple scapegoat for what happened to the US addict population.

Courtwright's study, written in the form of historical epidemiology, is revisionist in another sense also. His estimate, based on doctors' and chemists' surveys, records of maintenance programmes, and military medical examinations and import statistics, places the number of addicts in the US at around 313,000 before 1914. The official figure for this period was much higher, giving the impression that by 1919 there were one million or more US drug addicts and that the number was increasing. Data was fabricated or manipulated—notably by Hamilton Wright, US delegate to the Shanghai Opium Commission, for political ends. Penal legislation was passed on the premiss that addiction was sharply increasing, when in fact it was declining. Addict numbers had a clear political significance in policy formation, as they did in Britain at

[12] This point is made by M. Pelling, 'Who cares? NHS past, present, and future', *Bull. Soc. soc. Hist. Med.*, 1984, **34:** 62–63.

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the same time—and continue to do so, as the recent debate on the "hidden addicts", those not notified to the Home Office, demonstrates. Courtwright shows, too, how theories of addiction altered as the class and type of addict changed. The more liberal view of the addict as a "normal" person addicted accidentally made little headway against theories of the psychopathic personality, grafted in the 1920s and 30s on to the older view of moral insanity. These latter theories were more readily accepted because they seemed to fit the new criminal lower-class type of opiate addict. The change in the class of the addict population also transformed attitudes towards mandatory institutionalization. This was never a very successful option when the addict clientele was middle class and medically based, but gained strong support as the addict population descended down the social scale. Lexington Hospital, providing institutional treatments specifically for addicts, opened in 1935.

Courtwright's research is painstaking and thorough—although he does tend to list evidence without assessment as if it were all neutral and value-free. For example, the racial fears about white women, opium-smoking and Chinese men, also common in Britain from the 1890s and particularly strong in the 1920s, are simply presented without analysis. Courtwright also has little about lower-class non-iatrogenic use and addiction in the nineteenth and early twentieth centuries, presumably because this is much less easy to document. His nineteenth-century material emphasizes mainly the types of medical and middle-class addicts who were most written about, rather than those who did not come to medical attention. And his use of import statistics to estimate addict numbers, while ingenious, does make a number of assumptions based on the likely amounts of opium not used by addicts. But in general, the book provides not only a well-written corrective to some of the historical myths which have influenced US drug policy, but also a valuable study of changes in the addict population and medical and policy reactions to it.

Wayne Morgan's survey of drugs in America from 1800 to the 1980s has no such revisionist aims. Beginning with the nineteenth-century "therapeutic revolution", he covers the increase in addict numbers, treatment of addiction, international regulation and the Harrison Act, and the long reign of Harry J. Anslinger, Commissioner of Narcotics from 1930 to 1962. He brings the story more or less up to date, with a final chapter on the liberalization of drug control in the 1960s and continuing debates on drug use in the succeeding decades. Some of this is quite familiar from other works on US drug policy, notably David Musto's *The American disease* (1973). Where Morgan's book covers areas also considered by Courtwright or Musto, it does not compare well. Morgan's discussion of addict numbers, for instance, is simply a run-through of different estimates without any assessment. His discussion of contemporary perceptions of the role of heredity and predisposition to addiction itemizes types of explanation without a sense of social and cultural context. The book is of some use as a general survey of this extended period, but it badly needs some historical conclusions and a more analytical attitude to the historical material it contains.

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