Underground and under steam: liquor smuggling during Prohibition

I take issue with Dr. Mark Latowsky's claim that Prohibition reduced the consumption and availability of alcohol (*Can Med Assoc J* 1996; 155:860-1). I find it impossible to accept any statistics, because the enforcement agencies reported only on their successes. As in the drug trade, the honest experts admit that most contraband gets through to its destination.

I had a family practice on the east coast of Canada for 40 years. I soon realized that nearly all of the history of Prohibition in this region was being lost because nobody was becoming the confidant of those involved on both sides of the law in the four Atlantic provinces. My wife and I decided to fill this void and commenced a 35-year hobby collecting documents and photographs and taping recollections. We have written three books with a total circulation of more than 25 000 copies. Quotes from two of the books refute a common misconception.

> Between 1920 and 1941, many hundreds of vessels of all shapes and sizes scurried up and down the Atlantic coast taking liquor in one form or another to the United States and Canada. The quantity of alcohol involved was so large that it boggles the mind. . . . There is a list (taking up an entire page) of the liquor passing through the port of Halifax in only a few weeks in 1925. The destination of all of it was for the United States, for the manifests were fakes. Yet Halifax was only one of the routes used. Some was taken directly from Saint-Pierre et Miquelon, from St. John's in Newfoundland, from Saint John in New Brunswick, from Bermuda and directly from Europe. It came up from the Caribbean, it came across the Great Lakes, and the land borders of Canada and Mexico.[1]

> On 16 January 1920, the American Prohibitionists celebrated the demise of John Barleycorn, the personification of their enemy. Most of the fanatics had unreal expectations that the thousands of agents, newly appointed to enforce the Volstead Act, would root out and destroy alcohol from coast to coast. Mr. Barleycorn may have been slain, but he wouldn't lie down. To the north, Canada had already demonstrated that temperance statutes enacted some years previously had made no difference to the consumption of alcohol. It only made availability somewhat more complicated. Even on the home turf of Capitol Hill, senators and congressmen used the celebrated "Man with the Green Hat" to keep their liquor cabinets full.[2]

Prohibition drove liquor drinking underground. I do not believe it lessened it.

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References

1. Robinson GE, Robinson D. *It came by the boat load*. 4th ed. Tyne Valley (PEI): G. & D. Robinson, 1993:1.
2. Robinson GE, Robinson D. *Duty free*. 1st ed. Tyne Valley (PEI): G. & D. Robinson, 1992:80.

Low morale: history lesson and farewell to faceless institutions

I read with interest the article "Why is physician morale so low?" (*Can Med Assoc J* 1996;155:978), by Dr. Douglas Waugh. However, I must point out an error. Ambroise Paré was on the battlefield nearly 300 years before Napoleon's time. He was the personal surgeon to the Marshal de Montejan, a general of the French king Francis I. It was at the siege of Turin in 1537 that Paré ran out of burning oil to cauterize the gunshot wounds of the soldiers and resorted instead to a balm made of "digestive of yolks of eggs, oil of roses and turpentine."

Napolean fought his battles centuries later, during the end of the 18th century and the early part of the 19th century. His principal surgeon was Dominique Larrey. Larrey invented the field ambulance, which was horse drawn in Europe and camel propelled in Egypt. I do not know what physician morale was like in those days, but I suspect it has followed a sine curve throughout the ages.

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This summer I moved to Ohio from North York General Hospital, North York, Ont., where I had been an otolaryngologist for almost 15 years. As a result of my soul searching before this move, I better understand the roots of my dissatisfaction with working as a surgeon in Ontario.

The problem with being a physician in Canada is that we serve a myriad of faceless institutions in different ways. For federal politicians, we obey the Canada Health Act in order to keep the New Democratic Party at bay throughout English Canada. For provincial politicians, we do our part to balance the budget. This meant that, before I moved, I was being paid 10% less than what I had received in 1988. I also had a cap on my practice income, and my hospital was subject to 5% cutbacks, despite a 4-month waiting list for surgery. For hospital administrators, we keep the citizens of our neighbourhoods happy and cover the hospital for emergencies.

All of these forces end up devaluing medicine. I went into medicine to use science and technology to better people's lives. Medicine was never meant to be the glue that binds the country, the problem area of government expenditure control or some sort of public relations gesture for a hospital administrator.

I find the situation here in the

United States much healthier because my mandate is clear — to provide the best care feasible in a timely and efficient way. I knew that I had made the right decision when I treated my first patient in the emergency department here. I was sewing up a compound nasal fracture on a young lady when her boyfriend turned to me and said, "It sure must take an awful lot of training to learn to do what you're doing, Doc."

Physicians who choose to stay in Canada can only be happy if they resign themselves to doing their bit to keep the country united, balance the budget and take care of emergencies. It they try to maintain the high standards that they were taught in medical school, they will only continue to be depressed, for no one who makes decisions about funding health care really cares about medical standards. Medicine in Canada has been devalued too much for too long by too many people.

Andrew Reid, MD, FRCSC
Findlay, Ohio

[The author responds:]

I am grateful to Dr. Clein for setting me straight about Ambroise Paré. History was never one of my strong subjects, although I seem unable to resist the occasional temptation to stick my nose into it.

Dr. Reid's comments about Canada's medicare system echo many that are heard throughout this land, and I am sure he knows that there are many who share his views. The often-stormy relationship between Canada's physicians and medicare certainly constitutes one of the reasons for low physician morale in this country and doubtless accounts for the departure of many fine physicians for the less restricted pastures of the United States.

Unlike Reid, I like to believe that the ills of our society will, in the long run, work themselves out. However, I cannot blame him for having neither the conviction nor patience to wait for this to happen. Perhaps, being older, I am no longer as feisty as I once was. He gives me another reason to regret this.

Douglas Waugh, MD
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Lessons learned from Britain

Dr. W. Grant Thompson is to be commended for his article "Contemporary English health care: What lessons can we learn from it?" (*Can Med Assoc J* 1996;155:581-4).

Although Britain, like all Western countries, is having difficulty coping with the cost of health services, people there are generally well serviced and have remained free to use private services if they wish. This is much more effective than the situation in the United States, where a third of the population is inadequately served and another sizeable group of people are impoverished by their efforts to obtain private services.

I was taught that one should use words as though they were bullets from a rifle, not shots fired out of control from a shotgun. Thompson crystallized for me the present situation in Canada. Everything is being revised at the same time, like shots from a shotgun. Thompson has fired from a rifle and identified specific developments in Britain that would change the Canadian situation constructively. We should organize our family medicine (general practitioner) services as they have in Britain, and we should allow the development of private services to meet any excess demand, including general practice, specialist care and hospital services.

We can all learn from Thompson's timely contribution and deal with specific services and issues rather than reorganize all aspects of our health care system.

Charles A. Roberts, MD
Victoria, BC

[The author responds:]

Dr. Roberts enthusiastically cites two examples from my article. The first is a suggested organization of primary care, which I believe may correct many of the abuses and inefficiencies of the present Canadian system. However, in the case of the development of private services, he has overinterpreted my article. There seems little need for privatized primary care. Like many, I am troubled by the notion of a completely separate private health care system. A public system of primary care, like that in Britain, can assure every citizen of prompt attention from his or her family physician while realizing savings through avoidance of duplication of services.

Nevertheless, we do need the freedom to innovate in the management of expensive secondary and tertiary services, for which public funding is under serious strain. An infusion of private money through private coverage for certain elective services, such as cataract or hip surgery, may be the only way to avoid the long waiting lists that are the bane of the British system. Properly managed, private coverage for such services for those who can afford it could reduce the pressure on the public system to everyone's advantage. We cannot be so smug about our vaunted system that we allow ourselves to be restrained from such innovation by the ideological provisions of the Canada Health Act. Single-tier health care is an unattainable dream in a global