"A State Bordering on Insanity"? Identifying Drug Addiction in Nineteenth-Century Canadian Asylums

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Abstract. This article examines the growing awareness of drug addiction as a form of mental illness in several Canadian lunatic asylums in the last half of the nineteenth century and the beginning of the twentieth. Whereas in the 1870s and 1880s, medical and reform associations formed to cure and treat addiction and inebriety, asylum evidence suggests that it was not until the turn of the century that drug habituation was considered a condition which merited admission to asylum. Prior to the turn of the century, drug use appeared in the psychological profile of asylum entrants only as an attendant condition of a more traditional form of mental illness, such as mania or melancholia. Asylum physicians, seeking traditional categories, and utilizing subjective classification methods, generally would not consider addiction to be a distinct mental illness. At the end of the century, shifts in diagnostic convention and the official endorsement of those shifts signalled a change that was taking place in the asylum. The impact of drug addiction on the psychological profile of a patient was attracting more attention in the asylum. Subsequently drug addiction joined other earlier causes of mental illness, such as masturbation, and also began to be recognized as a mental condition worthy of treatment at the public asylum. Its status as mental disease proper, however, remained a point of debate.

Résumé. Cet article examine la progression de la perception de la toxicomanie comme une forme de maladie mentale dans plusieurs asiles canadiens durant la deuxième moitié du XIXe siècle et le début du XXe. Alors que dans les années 1870 et 1880, des associations de médecins et de réformateurs furent créées pour traiter et guérir la toxicomanie et l'alcoolisme,—il semble qu'il faille attendre le tournant du siècle avant que l'habitude de la drogue soit considérée comme un état qui mérite l'admission à l'asile. Auparavant, la consom-
In the 1870s and 1880s, formal organizations of physicians and reformers formed to examine specifically the “disease of inebriety.” These self-declared specialists saw in addiction to drugs and alcohol a serious social problem that required treatment. Yet, while these organizations included drug habituation within their purview, the creation of the American Association for the Study and Cure of Inebriety, and the British Society for the Study of Inebriety did not necessarily indicate a shift in the awareness of drug addiction by doctors who did not make inebriety a specialty. The very nature of the specialty meant inebriety physicians sought and treated pre-identified habitual substance users. Patients arrived at various treatment institutions—mostly private retreats, asylums, or hospitals, and private practices—with their substance use already identified: they came looking for treatment for their addiction. However, to the unsuspecting eye, drug addiction was not readily identifiable. The addict manifested physical and mental characteristics that were not specific to drug habituation. What happened, then, when drug-using patients arrived at asylums with a condition that was not immediately obvious to physicians? More specifically, how did doctors view addiction when they were not looking for it? Did they consider addiction to be a cause or effect of other mental illnesses? When did addiction become itself a reason for asylum treatment, if at all? This article uses the records of several public asylums in Canada during the nineteenth and early twentieth centuries to explore these questions. It looks at the cases in which drug use was identified, but in which drug use played a variety of roles in the psychological history of the patient.

The study of asylum treatment of addiction has generally revolved around the specialist asylum, and especially the inebriety asylum. While demonstrating the growing concern about addiction to drugs and alcohol, these examinations do not explore the gap between the knowledge of specialists, and that of physicians engaged in general clinical practice. As Howard Shaffer has noted, clinicians operate under...
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a static and invisible diagnostic paradigm, and "practitioners generally do not recognize the extent to which they are committed to viewing the world through a particular perspective."5 Faced with a condition like addiction, which presented a set of recognizable physical and mental debilities, physicians often overlooked drug use as a cause of the psychological illness, classifying these patients under more traditional categories of mental alienation, notably mania, melancholia, dementia, and idiocy. These classifications were centuries old, and reiterated in the changing field of mental asylum medicine that arose from the end of the Enlightenment. People like French physician Philippe Pinel introduced new subcategories of insanity, such as partial and affective insanity, but did not stray far from the traditional delineations. A key issue for doctors in the early part of the nineteenth century was how these forms of insanity manifested themselves in organic damage. By the middle of the century, doctors who made the treatment of insanity their specialty clung to a somatic view of insanity even though they repeatedly failed to find any physical basis for these conditions.6

The lack of identifiable physical lesions and other organic cues to the causes and forms of insanity drove a highly subjective form of diagnostics, relating both to physical and moral conditions. As Gerald Grob noted, "mid-nineteenth century psychiatrists managed to infuse moral value and science into their models of insanity."7 Without distinct tests to identify forms of mental illness, asylum doctors relied upon physical and behavioral abnormalities to direct them towards a diagnosis. It is important to restate that psychoactive drug use, like alcohol excess, results in physical states and behavioral conditions that are analogous to the traditional forms of mental illness. In many accounts of addiction, the patients were emaciated and drawn; some exhibited manic symptoms, while others were desultory, despondent, and often suicidal. Canadian public asylum records suggest that this adherence to a rigid diagnostic paradigm persisted until the turn of the century. These records indicate that drug use entered the lexicon of asylum diagnostics through traditional channels. It was first a cause of other forms of insanity, such as melancholia and mania, and later became itself a form of mental alienation. In several instances, the records suggest a drug habit may have been the primary factor behind the condition, but that habit rarely was considered a central cause of the insanity. After the turn of the century, when new diagnostic conventions and a growing social awareness of drug addiction made the condition a legitimate form of mental derangement, the concept of addiction informed the subjective nosology of asylum medicine.

Drug habituation was not unknown in Canadian medical and social life in the nineteenth century, but it was not considered a social problem
until the end of the century. As early as 1849, a legislative committee of Upper Canada looking into liquor legislation compared drinking to an opium habit. In 1869, a doctor in Ottawa reported on the morphine addiction and death of a barrister patient, but his concern was less with the behavior of the addict than with the excessive amount of morphine the man could consume. In 1878, the Canadian Monthly printed "The Opium Habit," a story detailing a patient’s iatrogenic addiction, complete with DeQuincey-style descriptions of the author's heroic struggle to escape the drug habit. Although drug use was not unfamiliar to Canadians, then, its presence was difficult to identify. Compounding the problem of diagnostics was the potential that addicts would not disclose their condition. The Provincial Inspector of Ontario observed in 1886 that any list of causes of insanity would be flawed because, amongst other reasons, the family or the individual may not wish to divulge embarrassing information, such as "if the patient has been addicted to any particular vice or excess." Long before medical investigators attached a social opprobrium to drug addiction, Thomas DeQuincy preferred to keep his addiction secret, and published his first version of his Confessions of an English Opium Eater (1821) anonymously. This recognition of the secrecy of drug users was not confined to the users themselves nor the medical profession. The Upper Canada legislative committee of 1849, which was investigating the province’s liquor laws, recognized the idea that drug use was a solitary indulgence. Mr. Gugy, the committee chair, argued that opium eating would never become as prevalent as liquor because opium inspired solitary consumption, while liquor was a social vice.

The solitude of the drug user fit a pattern of behavior that concerned asylum physicians: the improper and introspective focus of mental energy, a state that reiterated the uncertain relationship between addiction and asylum psychology. Beyond simply presenting a physical or behavioral condition that suggested an insane state, drug addiction also related to a moral condition that indicated insanity: "morbid introspection." As Michael J. Clarke has discussed, a key aspect to theories of mental alienation from as early as 1800 was the belief that conditions like morbid introspection—the act of focusing too persistently upon a single activity or idea—were central causes and forms of insanity. Moral treatment, which attempted to redirect the patient’s attention to a variety of "healthy" pursuits, attacked that single-mindedness. Clarke mentioned masturbation specifically as a form of particularly aberrant behavior to Victorian physicians, which contributed to, and was indicative of, deeper mental derangement. The drug user's tendency towards secret or solitary activity paralleled the behavior of a masturbator. The thematic similarity between masturbation and addiction as causes of in-
sanity should not be overlooked as merely coincidental, since both preoccupations in those deemed insane reflected a dominant theme in nineteenth-century psychiatry, the concern over morbid introspection. The behavioral similarities between masturbation and drug addiction enable us to speculate that, as it became more widely recognized, habitual drug use was another one of those single-minded pursuits that doctors felt could not possibly have been healthy. To physicians, recreational drug consumption, unlike alcoholism, was self-indulgent, inspired introspection, and had no practical purpose. It also spent vital force and misdirected time and energy in a developing industrial civilization forged by a work ethic that eschewed self-indulgence and wastefulness.\textsuperscript{15} Drug addiction, therefore, bore aspects of behavior that fit into Victorian psychiatric diagnostics, yet the addiction itself did not need to be recognized for a drug user to be a candidate for asylum treatment. The transformation of the awareness that drug use might be the central cause to some mental alienation did not happen in asylums until the turn of the century; even then diagnostics were subjective, and determined by the influences and impressions of the asylum physician.

In the admissions process, the asylum physician's first impressions of patient behavior and appearance combined with their conception of mental illness to form a preliminary diagnosis that would determine classification and treatment.\textsuperscript{16} Provincial governments entrusted the care of the insane to a medical superintendent and his staff, while the decisions to send the patient to the asylum came from several directions. Examination and referrals by general practitioners, documented in admission forms, paved the way to the asylum gate. This documentation provided the asylum staff with an initial impression of the patient's case up to the time of his or her arrival, and could be crucial to adequate treatment, yet it was often incomplete or otherwise flawed.\textsuperscript{17} T. Millman, Second Assistant Physician at the London Asylum, noted in 1880 that doctors needed to observe proper diagnostic procedures to aid the asylum personnel in their treatment.\textsuperscript{18} Patients also could arrive at the asylum from a gaol upon a warrant from the Lieutenant Governor. In this case, the patient was in gaol for safekeeping or for committing a crime or mischief. Warrant patients required the assessment of one doctor, and the endorsement of a magistrate.\textsuperscript{19} With these diverse impressions, the admitting officers generally recorded the information provided on the referral letters, along with other qualitative data provided by family, friends or the police officers who brought the patient to the asylum, and based initial diagnoses upon these impressions and their own perspectives.

Drawing upon personal knowledge of physical processes, accepted wisdom regarding mental illness, and practical experience to diagnose
incoming patients, asylum physicians often rejected the opinions voiced in referring documentation. These interpretations demonstrated that asylum physicians often employed generally static diagnostic paradigms that precluded the recognition of new varieties of mental illness. They often sought conditions to explain behavior that fit an etiology based upon prior experience or personal, highly subjective perspectives, thereby challenging the diagnoses of referring practitioners. For example, John Waddell, the first superintendent of the St. John Asylum in New Brunswick, was an ardent temperance reformer whose temperance perspective may have colored his diagnoses. He often sought indications of alcohol inebriety to explain the behavior of boisterous patients. For a man who arrived at the asylum in February 1863, Waddell observed that there had been “no report of his being in liquor,” although the symptoms suggested otherwise. More perplexing for Waddell was Michael Q., brought to the asylum by police, and acting rowdy, not unlike “someone who had partaken of a stimulant, but [the police] could not detect the alcoholic breath.”

Other physicians' comments suggest similar diagnostic presuppositions, often challenging the information provided in referral forms. While assistant physician in the London Asylum, Stephen Lett, who would go on to become the foremost authority on addiction in Canada, noted of one patient’s admission forms, “Causes said to be unknown but I (S. L.) fancy drink.” When trying to determine if another patient’s condition was hereditary, Lett commented that, “Friends say not hereditary, but I (S. L.) think this doubtful.” Masturbation was a similar convenient diagnostic category into which physicians placed suspicious cases. One patient at London was “in good bodily health; looks like a masturbator.” At the Toronto Asylum, the admitting physicians occasionally rejected the exciting causes suggested by referring doctors, and inferred the “solitary vice” instead. One patient’s insanity was “said to be [the] death of his mother, but masturbation more likely,” and another’s doctor suggested the cause was sunstroke, but the admitting physician observed “more probably masturbation.”

This tendency to seek causes where none may have existed, and to marginalize the observations of referring physicians and others who were more familiar with the individual patient, reflects a significant aspect of asylum medicine. While demonstrating the subjectivity of asylum diagnostics, it also implied a belief in the power of the medical superintendent over the field of psychiatry and challenged the referral system which asserted the authority of physicians in the state’s control of social deviants. It reinforced a hierarchy of psychological knowledge, at the top of which sat the asylum medical staff. It therefore contributed to the professionalization of asylum medicine as a specialty. Most nota-
bly, it also challenged a tenet of medicine which contributed to the authority of the broader medical profession. Doctors often argued that the specific nature of disease was unique to each patient, and thereby required individualistic treatment. Yet asylum physicians' tendencies to extrapolate complex conditions from general symptoms challenged the spirit of that medical knowledge. Moreover, disregard of letters of referral also made asylum physicians liable to overlook key aspects of the patient's condition. Taking patients from across the region, medical superintendents rarely had prior knowledge of the individuals who arrived at the asylum gates.

THE PLACE OF DRUG USE IN NINETEENTH-CENTURY PSYCHIATRIC CONCEPTS

Many descriptions of patients arriving at the asylums suggested the potential that the patient used drugs, but before the last decades of the century, physicians rarely considered habitual drug use as a cause of insanity. For asylum physicians, drug use might be an effect, but rarely a cause, of mental illness. Drug use played a specific but ancillary role within the nineteenth-century relationship between mind and body. As Charles Rosenberg has shown, the idea of psychosomatic illness had an entirely different meaning in mid-nineteenth-century medical treatment; physicians often attributed physical disease to mental or moral dissolution, and mental derangement similarly could be the result of physical causes.\(^{26}\) This conception appeared in diagnoses when a physical shock could be linked, however remotely, to a mental illness. In most asylums, the superintendents encountered some patients whose insanity was apparently the result of such physical shocks, like being dunked in or showered by cold water, or the shock of excessive medication.\(^ {27}\) For example, Michael M., an Irish farmer, arrived at the Toronto Asylum in June 1847 with a condition that was "thought to be from taking med. which did not agree with him." He stayed there for the rest of his life.\(^ {28}\) Likewise, physicians attributed the derangement of Delilah H., a 26-year-old domestic who arrived at Toronto in 1864, to "med'n used for bronchitis."\(^ {29}\) In these cases, the medicine sparked a psychosomatic reaction that created a fully formed mental illness.

Basing their assessments upon physical appearances, subjective references, and personal experience, physicians often understated or missed key factors in the individual's condition, such as drug use. Admission registers illustrated the initial point of contact between the asylum physician and the patient, and were not necessarily an accurate depiction of the conditions surrounding the individual's alienation. In the St. John asylum, Waddell also often attributed behavioral change that may have resulted from drug use to other, more orthodox, diagnoses. A clear example of the reluctance to consider drug addiction to be a key
aspect of mental alienation was in the case of Joseph S., who had been treated for rheumatic affliction in the thigh and hip, and seems to have been a victim of classic iatrogenic addiction. The treatment of the leg was unsuccessful, and resulted in a maintenance supply of hypodermic morphine to deal with the pain. "[A]bout 8 months ago he first showed symptoms of imbecility which increased to a form of hypochondriasis. [The patient] was formerly lively [and] cheerful, is now sad and despondent, and the tendency is to injure himself by taking morphine." Joseph’s case demonstrates the potential to view an addiction as another form of mental disorder. The physical manifestation of prolonged opiate dependency could appear as a form of depression or imbecility. The "potential to injure" suggests an indefinite conception of the results of taking large doses of morphine. Was the patient attempting suicide, or just using an amount of morphine that could be fatal to one who had not developed a tolerance? Finally, a desire for repeated doses of medicine like morphine could fit a loose definition of hypochondria. That Joseph was an addict seems highly likely; that his addiction was not initially identified suggests the difficulty physicians had in recognizing addiction when they were not yet looking for it.

Opiate addiction was not alien to physicians, but it needed to be recognized in its proper social and cultural context. Prior to the end of the century, that context included such suggestive imagery as opium dens and a link to Asian opium consumption. Not surprisingly, the only case in which Waddell recognized opium addiction was that of William M., who had become addicted to opium while in Asia. Here again, Waddell—and the referring physicians—initially diagnosed the condition with more common categories of concern, despite a history of opium use. William arrived at the asylum as a "suicidal drunkard," but Waddell’s description of the case chronicled the process of the patient’s opium addiction. The man "had previously been to the East Indies as Capt[ain] of a ship, and it is supposed that he contracted there the inordinate use of opium." Once he returned to Canada, he lost his supply of opium, and spent the winter in a state of delirium. "He had so far [ceased] . . . his opium in May that he crossed the Atlantic as a mate in a ship of his father intending to go East again, but having returned to his old habits again in Liverpool, he was [urged] . . . by the Capt. of [the] ship to return home. . . . " William’s experience reflected many of the cultural presuppositions and contexts of opium in Western society prior to the end of the century. The slow decline into opium, exposure to the dens in Asia, the pain of release, the return to old habits, and the moral and physical decay that resulted (he arrived at the asylum "dissipated and dark") were the images from contemporary alarmist narratives describing the dangers of opium. However, even with this suggestive
history, William did not arrive at the asylum until he appeared to display suicidal tendencies.

Whereas in the cases discussed above the physicians did not diagnose the condition as addiction, and our observations must remain speculative, in some cases, the patients themselves admitted an excessive drug habit. Catherine A. conceded upon her arrival at Toronto in September 1884 that she habitually took 30 grains of morphine, yet her referring documents did not mention this condition. Although they recognized the extreme quantity of Catherine's opiate consumption, the asylum physicians were not certain that the drug use was the primary cause of Catherine's debility. The "morphia [was] stopped on admission which might clear insan[ity]," wrote the admitting physician. Here the direct relationship between insanity and addiction had not been established. The exciting cause of her condition was listed as "mental trouble upon loss of property." Likewise, neither physician who referred John M. to the Toronto asylum in 1895 mentioned the existence of a drug habit, but John admitted upon his arrival that "he had abused the use of chloral and other drugs." He was a model patient, "always acted quiet and gentlemanly" and appears to have recovered rapidly, a fact that further suggests his primary affliction was caused by the drug use. He left the asylum two months after his admission.

For some patients who arrived at the asylum, drug use did appear in their psychological profile, yet their physicians deliberated whether or not drug addiction itself constituted insanity. Dr. John Fulton sent Thomasina M. to the Toronto asylum in 1875, noting that hers "is more probably a state bordering on insanity, than active insanity [and] is apparently caused by the habitual and excessive use of opium." Thomasina confirmed her use of three to four ounces of laudanum each day, but her doctor could not decide if this was insanity. Charles O., who arrived at the London asylum in 1871, had been "under treatment by private practitioners who have by all appearances given him large doses of morphine or some other preparation of opium." Yet the referring physician was unable to determine if addiction was actually insanity, and questioned "very much this being a case of brain disease; I fancy the great trouble was the use of too much opium ... to procure sleep." For both of these cases, drug use was a problem, but it was not insanity.

Although drug use was likely a major factor in the mental disturbances of these patients, the diagnosing physicians placed the behavior into more familiar categories of mental illness before embarking upon treatment. Central to these categories was the socially aberrant behavior the illness caused. While it is not possible to rediagnose patients in these documents, we can suggest that drugs played an important role in affecting the condition of the patient prior to their arrival. Catherine
and John’s confession of drug use, the large quantities of opiates used by Catherine, Thomasina, and Joseph, the iatrogenic addictions of Joseph and Charles, and the recognition of William’s dependence, indicate important aspects of their conditions. Yet the doctors required traditional categories to justify treatment. Dependence upon extant classifications was bolstered by the fact that the patients were not sent to the asylum until they demonstrated behavior that challenged social norms. The patients were manic, melancholy, suicidal, or homicidal, and these conditions reiterate the social role for the asylum as a place to correct deviant behavior. Indeed, doctors did not necessarily need to identify addiction to treat it effectively. Since their approach focused upon treating overt symptoms, merely isolating an addict from his or her supply could effect a cure.40

DANIEL CLARK, RICHARD MAURICE BUCKE, AND THE ADDICTION OF EDWARD C.

While drug use in asylum patients continued to be a rare occurrence, by the end of the nineteenth century asylum physicians had begun to recognize that drug use was more directly a factor in mental illness. Nevertheless, classifications of mental conditions, and interpretations of the place of drug habituation in mental illness remained a highly subjective exercise. The cases described above do not permit us to appreciate the extent of this subjectivity, factors beyond the observed behavioral and physical indications of mental debility, and how drug addiction affected diagnoses of mental illness. The written case records generally reflect only one asylum physician’s impression of each case. We are rarely fortunate enough to have a case in which two medical superintendents, with distinctly different therapeutic approaches, assessed the same patient. However, in 1896, a patient arrived at the London asylum, and then was transferred to the Toronto asylum. His condition became the subject of considerable scrutiny by both Richard Maurice Bucke, of the London Asylum and Daniel Clark, of the Toronto Asylum. The case of Edward C. provides a valuable opportunity to compare directly how substance use operated in the subjective terminological realm of asylum diagnostics, and in the uncertain terrain of definitions of “insanity,” and its relation to society in general. Edward’s addiction caused socially disruptive behavior that was distressing to his family. Yet the different prognoses by two prominent nineteenth-century alienists also challenges some historians’ interpretations of the relationship between social class and the treatment of the individual addict.

When Edward, a resident of London Ontario, and a confirmed liquor, cocaine, and opium user arrived at the London asylum, it was after being treated for liquor and cocaine addiction at the Keeley Institute in
Dwight, Illinois (noted for Francis Keeley’s “gold cure” for alcoholism and drug addiction\textsuperscript{41}), and then a series of misadventures in Georgia. He had hallucinated that people were trying to kill him, he threatened the life of his wife, and he attempted suicide in an Atlanta police lockup. When his family took him to the London Asylum, after retrieving him from the Atlanta authorities, he was described as “intemperate, has used cocaine, alcohol and opium. Imagines that his family have all turned against him. . . . Hesitating speech and tremors. Excitable. Incoherent and talks about great wealth and fortunes he is making. Excitable. . . .”\textsuperscript{42}

Prior to departing on his exploits in the United States, Edward had incurred a number of debts and had misused trust funds from his father’s estate. These activities took place while Edward was “laid up” from drinking and possibly from other drug use. Apparently as a result of these debts, the Toronto General Trusts Company sued Edward’s family to retain control of the estate of Edward’s father. The exact conditions around this case are not clear, although it seems likely that Edward’s brother, Andrew Jr., appealed to the TGT Company to place into safer hands the money that was intended for dependent relatives, but for which Edward was responsible.

To facilitate this court case, the family barrister, Mr. Gamble, requested a psychological evaluation of his client. Bucke examined the patient, collected a mass of paperwork describing Edward’s various exploits, and declared him “an insane person and a dangerous lunatic.” Bucke drew mostly upon accounts of Edward’s “moral” behavior:

He has been careless and reckless in his life and in his business, has drank spirits almost continuously in sufficient quantity to keep him a large part of the time in a dazed state, and has spent money so much in excess of his income as to deprive his family . . . of the ordinary comforts of life. . . . The people who have stood by him for years . . . who have assisted to support his family, who have supplied him with money . . . he looks upon with indifference or as his enemies . . . seems indeed to be destitute of any feeling of obligation or gratitude.\textsuperscript{43}

Bucke concluded that Edward was “a moral imbecile,” who “cannot recover from his debility, and [it is] very doubtful if [he] will ever recover from his delusions.” Gamble then asked Daniel Clark to examine the patient. Clark’s observations drew upon the same documentary evidence as Bucke, combined with personal interviews, but he concluded that Edward was not insane. Bucke had considered the aberrant moral behavior; Clark looked at the gaps between these fits of insanity.

Assuming all that has been stated . . . to be true, it is evident that intermittently he was subject to hallucinations and delusions. It is, however, noticeable that also intermittently he was rational and in his right mind and did at these times intelligent work. . . . It is evident then that there was no fixed or permanent brain
Disease at this period, else would his delusional state have been continuous and incapacitated him from earning a salary in responsible positions.

Clark did not deny the "strange conduct" and hallucinations were the behavior of "no man in his right mind," and drew the Inspector's attention to "the fact that he not only drank liquor heavily but was also a victim of cocaine, which he acknowledges, and experience teaches us that the excessive use of these deleterious poisons not only causes delirium, but also often excites to hallucinations of sight and hearing as well as delusions of persecution." Clark was adamant, however, that "these intermittent periods of undue excitement cannot be rightly called insanity." Clark likened Edward's insistence that the delusions in Georgia had actually happened to the strong impressions made by dreams, which "impress us with an intensity almost equal to real actions and waking mental impressions." Contrary to Bucke, Clark suggested that Edward could be released on probation, to see if the patient had recovered. This probation began in January 1897, and in March Edward was formally discharged.

Bucke's and Clark's opinions are consistent with their published perspectives on the nature of the human mind, and the effects of drugs upon it. In his book Mental Diseases (1895), Daniel Clark refused to consider all drug addiction to be insanity. "The delirium or mania induced by ... toxic agents such as alcohol, opium and its salts, cocaine, hydrate chloral and such like, are not insane conditions," he argued. He disagreed with authors who called such states "toxic insanity ... alcoholic insanity, morphinic [sic] insanity, haschish [sic] insanity, etheric [sic] insanity, chloralic [sic] insanity, haschish [sic] insanity, and oxy-carbonic insanity." He argued that the only time delirium caused by substance use should be properly labelled insanity was when "a permanent mental disease follows the use of and abstinence from these drugs." For Clark, Edward's case was a temporary condition, one that was nothing more than a temporary condition. That Edward was lucid and rational upon cessation of the substances suggested that no mental disease was present, and that the patient no longer required institutional oversight.

Bucke's writings focused less upon the biological or organic nature of insanity, and more upon broader questions of the moral nature of the individual and the human race. S. E. D. Shortt and Rainer Baehre both have explained that in his work, Bucke consistently argued towards the developing moral superiority of humanity, validating this perspective with organic theories of moral growth. In his celebrated Cosmic Consciousness (1901), Bucke argued that humanity was reaching a moral transcendence that few had yet achieved. Although Shortt and Baehre did not mention the case of Edward C. specifically, their explanations of Bucke's perspective illuminates the doctor's interpretation of Edward's
condition. Edward, an individual whose willful indulgence led to violence, abuse, and rejection of the sympathies of others, was, to Bucke, an irredeemable individual, and a potential example of what Shortt calls "atavism...regression to a more primitive state." Edward’s refusal to admit his hallucinations, and his history of aberrant behavior, suggested to Bucke one who was morally regressing, instead of developing. Both physicians’ arguments related to broader issues of social progress and the role of addiction as deviance within the larger social context; both considered the class of the patient, but his social status drove the doctors’ distinctly different recommendations. Clark drew upon generally accepted truths regarding the effects of drugs upon the behavior of the individual, but offered an optimistic assessment of the prospects of treating addiction. Addicted to drink, cocaine, and (in some accounts) opium, Edward personified the social panic over the substance abuser. He was a wealthy man who had indulged too frequently. He fell into bad habits, and became delusional and unable to keep his job. His addiction led to temporary insanity, which in turn caused havoc to the family and potential danger to society. For Clark to view the potential restoration of the individual’s faculties was for him to offer hope to society’s growing “problem” of substance use. Bucke, meanwhile, provided no solution but perpetual incarceration and pessimism. His class-based interpretation of progress meant that when a wealthy individual squandered his property and abused his relatives and peers, that individual’s behavior demonstrated a threat to the positivistic, progressivist perspective that Bucke embraced. For the superintendent of the London Asylum, insanity was the only way to explain such behavior.

Bucke and Clark’s observations of Edward’s condition occurred during a period of transition in the diagnostic appreciation of addiction. Neither was willing to consider the addiction itself to be a form of insanity, but both recognized drug use as a problem requiring treatment. The key difference was that Clark saw drug use as a temporary aberration in an otherwise clinically sane individual; Bucke saw drug use as proof of insanity. Bucke linked Edward’s addiction to a broader social panic that could not be solved merely by removing the drugs and returning the individual to society. Clark was more sympathetic to Edward’s condition, possibly owing to the doctor’s experience with patients in the “superior” ward of the Toronto Asylum, which housed wealthier insane patients. The assessments of these doctors demonstrate what Timothy Hickman has recently called the “double meaning of addiction,” relating to the class of the individual addict. Addicts requiring punitive treatment, notes Hickman, generally came from poorer or “criminal” classes; addicts who deserved more forbearance were wealthier individuals. The case of Edward C. however, suggests
that these classifications need not be tied exclusively to social status. One addict could require both punitive oversight and forbearance, depending upon the perspective of the physician.

TURN-OF-THE-CENTURY DIAGNOSTIC SHIFTS

The diagnostic disagreements of Clark and Bucke in the case of Edward C. reflect a more extensive revision of categories of mental illness that occurred at the turn of the century. Classifications of mental illness were breaking down, and one result was a recognition that drug use could be a distinct form of mental illness. A number of medical developments and social factors effected this change. First, a growing awareness of the use of drugs in middle-class families, especially amongst women and professional men, fuelled a rising social panic regarding drug use. This panic was exacerbated by racial concerns regarding the decline of strong, white, Anglo-Saxon stock in the face of immigration to North America by eastern and southern Europeans, and panic over the Chinese in British Columbia. The direct effects of such social factors upon diagnoses are difficult to identify, yet the class and gender of individuals who were being admitted for drug addiction suggests these social patterns, and appear in the frequency that the asylum physicians recorded drug use in their official reports to the provincial inspector.

In 1889, for example, three patients had the “chloral habit,” and in 1896, two had the “opium habit.” By the end of the century, “morphine habit” was a recurring category, even though frequently no admissions were listed in that category. In 1897 the category was “morphine and cocaine,” a title which does not indicate whether the two were taken in tandem, or only recorded together. In the annual report of Dr. C. K. Clarke, the Superintendent of the Kingston Asylum, drug use merged with alcohol into the general category “intemperance in drink or drugs.” The notable increase in the cases of alcohol and drugs as causes of insanity, while not large enough for statistical tests, do suggest that those referring people to asylums, or the asylum physicians themselves, saw drug use more frequently as a viable cause of mental illness.

A closer look at the asylum admissions further illustrates the changes taking place at the asylum level. By examining the records of two asylums, Kingston and Toronto, we can see a pattern of increased frequency in the admission of identified drug users to these institutions. Kingston and Toronto are useful for examination because they appear demographically distinct. While both accommodated “pay” ($3 or $4 a week) and “free” patients, Toronto also had a “superior” ward, for patients who could afford the $6/week fee. Tables 1 and 2 detail this demographic difference. Table 3 provides information on the types of drugs the patients were using, and the fact that more of the drug combi-
nations were taken by men at Toronto seems to be a result of the gender and economic status of patients. Men at Toronto were much more likely to use a variety of drugs, or combinations of drugs, than were women at that asylum, and men and women in Kingston, all of whose drug use generally involved opium or occasionally opium and alcohol. Cocaine use was significant among the Toronto male addicts, but not to the other patients. Cocaine more often was combined with habitual use of other drugs, a trend that mirrors the findings in Warsh's study of Homewood. The first admission of a cocaine user at the Toronto asylum was an analytical chemist in 1895. Of the eight male patients whose drug use included cocaine, three were physicians: one of the patients used cocaine exclusively and two combined cocaine with morphine; a fourth doctor took cocaine and alcohol, and is thereby listed in the "other" category of Table 3.

Table 1

<table>
<thead>
<tr>
<th>Drug-Using Patients by the Amount Paid, 1875-1906</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Toronto Asylum</td>
</tr>
<tr>
<td>Men</td>
</tr>
<tr>
<td>Women</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

To $6   To $3  Free  Total
Pay     Free  Total

<table>
<thead>
<tr>
<th>Kingston Asylum</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>0</td>
<td>6</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Women</td>
<td>8</td>
<td>7</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>13</td>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>

Source: Admission Registers for the Toronto Asylum and the Kingston Asylum, 1875-1906, Archives of Ontario.

With these demographics in mind, we can consider the chronological shifts in asylum diagnostics at the two asylums. Table 4 illustrates the "Forms of Mental Derangement" in which drug use appeared either an exciting or less frequently predisposing causes in patients entering the Toronto and Kingston asylums. Since, as demonstrated earlier, drug use in the nineteenth century could often be misinterpreted or miscategorized, we cannot conclude that incidents of drug use increased, yet the growing incidents of drugs as causes and forms of insanity illustrate a changing recognition of the potential for drugs to alter behavior significantly. Combined with the qualitative evidence from asylum superintendents reports and categories, these statistics suggest a terminological
incorporation of drug use and addiction within the classification of cause and forms of insanity in the first decade of the twentieth century.

Table 2
Drug-Using Patients Compared, 1875-1906

<table>
<thead>
<tr>
<th>Patients</th>
<th>Pay</th>
<th>Free</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto</td>
<td>Men</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Kingston</td>
<td>Men</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>Men</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Women</td>
<td>18</td>
<td>8</td>
</tr>
</tbody>
</table>

Grand total | 32 | 19 | 51 |

Source: Admission Registers for the Toronto Asylum and the Kingston Asylum, 1875-1906, Archives of Ontario.

Table 3
Substance Used in Cases of Addicts, 1875-1906

<table>
<thead>
<tr>
<th></th>
<th>Toronto</th>
<th>Kingston</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Opium</td>
<td>2</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Opium and cocaine</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Opium and alcohol</td>
<td>7</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Other\textsuperscript{a}</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>19</td>
<td>11</td>
<td>6</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Including "other drugs"; patient was described as having a "drug habit" or cases in which the condition included "alcohol and other drugs."

Source: Admission Registers for the Toronto Asylum and the Kingston Asylum, 1875-1906, Archives of Ontario.

The second factor affecting the shifting role of drug use in asylum diagnostics came in the first years of the twentieth century, when governments endorsed new classifications. In 1908, for example, the government of Ontario legislated a new system for categorizing insanity based upon German alienist Emil Kraepelin's classification.\textsuperscript{58} The categories began with "Psychoses Associated with Toxaemia," which included the subcategories of "morphinism, cocainism, and several forms of dementia associated with alcoholism."\textsuperscript{57} Yet these classifications, reflecting a complex new way of conceptualizing insanity, and incorporating drug
addiction, could not escape the subjectivity of the asylum physician's diagnoses. Moreover, as Warsh noted, "the shortcomings of Kraepelin's work was that the innovation ended at classification." New classifications did not lead either to new treatments, or to a relinquishing of the highly subjective nature of asylum diagnoses. Patients were simply placed in more jargon-heavy categories, and treated the same as before. The social context of asylum diagnostics, demonstrated by Bucke and Clark continued long after the former's death in 1902 and the latter's retirement in 1905.

### Table 4

Form of Mental Derangement in Drug-Use Cases, 1875-1906

<table>
<thead>
<tr>
<th>Asylum</th>
<th>Gender</th>
<th>Melancholy</th>
<th>Mania</th>
<th>Drug habit</th>
<th>Other or N/A</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1875-89</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toronto</td>
<td>Male</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Kingston</td>
<td>Male</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1890-99</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toronto</td>
<td>Male</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Kingston</td>
<td>Male</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>1</td>
<td>8</td>
<td>0</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1900-6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toronto</td>
<td>Male</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Kingston</td>
<td>Male</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>1</td>
<td>4</td>
<td>4(^a)</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>22</td>
</tr>
</tbody>
</table>

\(^a\) Includes "Mania with cocaine habit."

Source: Admission Registers for the Toronto Asylum and the Kingston Asylum, 1875-1906, Archives of Ontario.

The gradual infiltration of addiction into the diagnostic taxonomy of asylum physicians accompanied a broader incorporation of drug use into the diagnostic perspective of asylum physicians. Just as doctors had prejudged certain behavioral anomalies to be the results of alcohol or masturbation, some evidence suggests that drug use became a similar presupposed cause of insanity. This change took place about the same time that drug use officially became a form of mental derange-
ment, but in Ontario it predated the official adoption of Kraepelin’s system. In Kingston, in 1907, the admitting physician began to note the absence of drug use in manic and demented patients who arrived at the asylum. A farmer suffering from “acute mania” had habits described as “industrious, temperate, no drugs”; a housewife with chronic dementia was “active intemperate no drugs”; and another with delusional mania was “active [and] not addicted to alcohol or drugs.” When we compare the referral forms, on which details of the cases were provided by the patients’ referring physicians, with the admission registers, in which the asylum’s admitting physician transcribed the information on these forms (and supplemented it with his own observations), we see a further tendency to regard drug use as a cause or form of insanity. A grocer who entered the paid wards at the Toronto asylum in August 1899, for example, was melancholy from the death of several children and business losses. His referring doctors noted these tragedies drove him to take “drugs, chloral and laudanum” but considered the predisposing cause of his derangement to be the loss of his children, and the exciting cause to be financial difficulties. Yet the admitting physician wrote that the cause was “alcohol, laudanum & chloral.” The man’s condition was probably caused by more than just addiction, however, since he remained for over two years.

The determination that drug use could cause insanity may have served to blur other conditions. Just as we must be careful when trying to identify addicted patients who were not described as addicts, we must consider carefully any attempt to reconsider a diagnosis that included drug use. Several cases for which drug use was a cause but not a form of mental derangement demonstrate that we must be cautious in our interpretation of any case. Nevertheless, the physical effects of drugs have some continuities, especially in the requisite time for overcoming the effects of detoxification. Given identifiable effects of the drugs we are exploring, we would expect a patient whose condition was caused exclusively by addiction to require a few months’ stay to recover from withdrawal symptoms; yet this pattern was not always the case. A woman at the London asylum, for example, had taken drugs for a tumor and the pain that resulted from it. The tumor disappeared, but she continued to take opium. She remained at the asylum for a year and a half. The same condition befell a physician from Stratford, who arrived in the London asylum in 1875. The exciting causes of his condition were “Morphine and [a] hard country [medical] practice.” Although removed from the country practice, and likely taken off the drug, this doctor remained in London for nearly three years. A physician whose mania both the referring and admitting physicians figured may have been caused by cocaine use, remained in the Toronto asylum for two
years, and was discharged "unimproved." A medical missionary who arrived at Kingston with both predisposing and exciting causes listed as "morphine habit" (but with no listed "form of mental disease") remained at the asylum for over five years before leaving "improved." These patients' histories suggest that their problems were deeper than a drug addiction.

CONCLUSIONS

Whereas specialists were carving out their drug addiction treatment niche as early as the 1870s, the evidence from several Ontario asylums suggests that it was not until the turn of the century that drug use was recognized as a viable cause of insanity. In the 1870s asylum physicians and general practitioners recognized that drug use could be involved in the mental illness of their patients, but before the last decade of the century a drug habit alone was not an issue of concern. It might have been a sign of deeper mental problems, but rarely a cause of them. By the first decade of the twentieth century, asylum evidence and government decisions suggest that the interpretation of the place of drug use in the spectrum of mental disorder was changing. More frequently, drug addiction itself was considered to be form of mental disorder, and one which could lead to other debased conditions. Reiterating this infiltration of drug addiction into the position as a viable form of insanity, drug use began to occupy the position that earlier behaviors like masturbation had once done: as a type of default diagnosis. Both were secretive practices that doctors believed could lead to insanity, and increasingly doctors sought drug use when faced with a cluster of conditions that they saw as relating to that practice, but for which no actual evidence of the behavior existed. This tendency to seek drug addiction as a cause of insanity may have served to mask other conditions that had caused the illness, reiterating the subjective nature of asylum diagnostics, notwithstanding the more sophisticated diagnostic categories developed by Kraepelin and accepted by the Ontario government. Since this article draws upon the records of a small number of asylums, we must be circumspect about drawing any broad conclusions from this examination. Nevertheless, the asylum evidence suggests that, whereas drug addiction was the purview of a small group of specialists who generally treated the addiction of the elites in the last third of the nineteenth century, more general awareness of drug addiction as a medicalized problem took longer to infiltrate the diagnostics of other physicians, who were not addiction specialists.
NOTES

1 Revision of a paper first presented at the Research in Progress Seminar, Queen Street Mental Health Unit, Toronto, May 1997.


3 While predominantly relying upon Ontario asylum records, this article also uses the records of the St. John, New Brunswick asylum to give evidence of earlier Canadian asylum diagnostics.


6 Roy Porter, “Psychiatry,” chap. 16 of The Greatest Benefit to Mankind: A Medical History of Humanity (New York: HarperCollins, 1997), p. 493-524; for a good example of Canadian adherence to diagnostic traditions, see Warsh, Moments of Unreason, p. 38-39; and Barry Willer and Gary Miller, “Classification, Cause and Symptoms of Mental Illness, 1890-1900 in Ontario,” Canadian Psychiatric Association Journal, 22, 5 (1977): 231-35. Note that, while Stephen Lett at Homewood used innovations to identify addiction, such as urinalysis (Warsh, Moments of Unreason, p. 38), such tests would only identify the existence of drugs in the body, not the more highly socially constructed condition of addiction per se. Also see Duffin, Medical History, p. 278-86.


9 Journals of the Legislative Assembly of Upper Canada (1849). Appendix ZZZ. See note below.

"A State Bordering on Insanity"?

11 "Report of the Inspector of Prisons, Asylums and Hospitals," *Sessional Papers of Ontario* (1885), p. 8. The inspector provided this qualification annually when discussing the table of "Causes of Insanity." This cryptic phrase likely referred to more commonly identified behavior, like masturbation or alcoholism, but what is significant in that quote is the fact that families kept some conditions secret.


13 The chair was probably Bartholomew Conrad Augustus Gugy (1796-1876) (*Journals of the Legislative Assembly of Upper Canada* [1849], Appendix ZZZ). I thank Martina Hardwick for finding this comment.


16 Warsh notes that at Homewood the patient's diagnosis was "a crucial step in his or her asylum career" (*Warsh, Moments of Unreason*, p. 37).


19 Unlike certificate patients, warrant patients were not free to leave once the asylum physician determined him or her to be cured. A warrant of discharge was necessary before a warrant patient could leave.


21 Saint John Lunatic Asylum Casebook, Michael Q., 3 February 1876, p. 115.


23 London Asylum Casebook (Male), Vol. 5, p. 242, patient #1012.

24 London Asylum Casebook (Male), p. 365, patient #1265.

25 Toronto Asylum Admissions Records, patients #4833 and #4925.


27 See records of the Prince Edward Island Asylum, Public Archives and Record Office of Prince Edward Island. Willer and Miller discuss the somatic causes of insanity in the case of the Lakeshore Psychiatric Hospital in Toronto between 1890 and 1900 (Willer and Miller, "Classification, Cause and Symptoms").

28 Toronto Asylum Admissions Register, Michael McC. patient #517.

29 Toronto Asylum Admissions Register, D elilah H. patient #3039.
30 Saint John Lunatic Asylum Casebook, 18 July 1871, p. 553.
33 Toronto Asylum Admissions files, patient #5810.
34 Toronto Asylum Casebook, patient #5810; emphasis added.
35 Toronto Asylum Admissions files, patient #5810. The role of morphine in Catherine’s condition remains unclear, however, since she died four days after her arrival.
36 His age is not clear. It may have been 31 or 37.
37 The asylum practice was to send patients on probation first. John was formally discharged soon afterwards (Toronto Asylum Casebook, patient #7773, p. 403).
38 Toronto Asylum Casebook, patient #4341.
40 Examining asylum therapeutics in Revolution-era France, Dora Weiner has shown how depletion regimens may have been successful in treating insanity because “they often weakened violent patients into compliance, so that they were pronounced cured and dismissed” (Dora Weiner, The Citizen-Patient in Revolutionary and Imperial Paris [Baltimore: Johns Hopkins University Press, 1993], p. 254).
42 London Asylum Admissions Records, patient #3952.
43 Bucke, Affidavit “In the High Court of Justice,” nd, in “Edward C.” file, Toronto Asylum Admission Records, Patient #8077.
45 Clark to Christie, p. 2.
46 Clark to Christie, p. 3.
47 The High Court decided that the TGT would have control of the Edward’s family estate. Since the specific reasons for the trial are not clear, it is difficult to comment upon this decision. However, it appears that Edward was the eldest brother, and so the TGT case was an attempt, at the request of the rest of the family, to get a third party in charge of the funds from Andrew C. Sr.‘s estate, to protect them from misappropriations like those of Edward. In that respect, this court decision was a victory for both sides.
50 On atavism and Bucke’s ideas, see Shortt, Victorian Lunacy, p. 100-1.
52 Valverde demonstrates this class-based interpretation of the treatment of alcoholism in “Slavery from Within.”
Superintendents made annual reports to the provincial inspector, who presented and often analysed these statistics in the annual "Report of the Inspector of Prisons, Asylums and Hospitals," in the *Sessional Papers of Ontario*.


Kingston Asylum Casebook, respectively, patients #4049, 4063, 4087.

Toronto Asylum Admissions files, patient #8532.

I am not assuming that all processes of detoxification are the same for all people, but that withdrawal would not have taken years.

London Asylum Casebook, patient #7202, 12 March 1892.

This case was one of the earliest instances of a direct link between drug use and insanity. One wonders if the man’s status as a physician may have influenced the diagnosis, since from the beginning of the shift in ideas about drug habituation, commentators (usually doctors) were concerned about physicians’ tendency to use drugs, often owing to the stress of their lifestyles.

London Asylum Casebook, patient #926.

Toronto Asylum Casebook, patient #8360.

Kingston Asylum Casebook, patient #3203.