Venereal Diseases and the Reform Enigma

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"The Lesser of Two Evils"

By

Susan Lemar

Cambridge
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This book first published 2019

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-2168-0
ISBN (13): 978-1-5275-2168-1

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"city of stenches"

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"a very queer Bill on a very queer subject"

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"to perish as driveling idiots"

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"a sounder plan"

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"ill-advised, unwanted, and unnecessary"

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PREFACE

There exists an enormous corpus of literature—germinating from the mid-nineteen seventies to the middle of the first decade of the twenty-first century—on the moral implications of venereal disease and how society sought to deal with the afflicted. The double standard of morality has been at the forefront of historical argument, which, for some, amounted to a crusade against the aspirations of women. The basic assumption underpinning the majority of this work has been that venereal diseases were a problem beyond public health policy. Generally, the conclusions of many historians have been informed by a simplified set of causes and effects. This includes the fact that governments tend inevitably to regulate social life through the elaboration of an apparatus of inspection and compulsion. As the argument goes, regulation tends toward the control of subordinate and relatively powerless social groups, such as women, by the elite. Popular assumptions include the persistence of Victorian concepts of morality, the dissemination and imposition of western medical knowledge, the role of the state in reaffirming sexual, social and racial subordination from the mid-nineteenth century and the criminalisation of illness under the auspices of public health policy. Missing from the literature to date is the contribution of frustrated social policy developers, the annoyingly tedious constraints of parliamentary processes, and the insatiable instinct for political survival, if not relevance. What is needed, now that the dust has settled on the subject, is an approach that recognises that these assumptions may have obscured the practical and complex issues surrounding policy development. As the historiography has suggested, the primary protagonists in this debate perceived venereal diseases as different from other infectious diseases and, therefore, should be treated differently under the law. Given the nature of transmission and the sensitivities involved, perhaps they were right to do so. In any case, it would not mean that this group of diseases, then as now, lies outside the auspices of sound public health policy. This was a time when health officials and social policy makers, confronted with what was essentially a health problem, were pummelled by ideologues remonstrating for solutions to tangential problems: such as the regulation of prostitution and ensuring racial purity. What is needed is an approach that recognises that the social and moral discourses that underscored the movement for

venereal diseases policy could be a hindrance to, rather than an instrument of, reform.

This assessment of the available sources places venereal diseases policy within the history of social policy development in two cities during a period that was characterised by a number of social movements, which had varying degrees of influence. It does not reject out of hand the approaches to date; it only attempts to set these themes in a broader context. Its goal is only to offer a different perspective: a socio-political one that may raise the public profile, but was not completely directed by, sexual politics, the ambiguity of the expert and the persistent chiming of pressure groups. At the end of the day, the process whereby one theory comes to replace another is likely to be more sociological than scientific. Although the changing views of experts may play a role, their views are likely to be controversial. Faced with conflicting opinions from the experts, politicians will have to decide whom to regard as authoritative and, therefore, the policy community will engage in a contest of authority over the issues at hand.[1] The objective here is to position the development of venereal diseases policy into a context where policy development is directed ultimately by the want of practical solutions rather than pandering to the cacophony of ideological rhetoric.

To position my analysis in the period of most attention (1970s to the mid-2000s), some of the sources I rely on are unapologetically "old". I have tried to highlight sources that were available to historians in that period. For example, the eugenics movement in disease control policy was often bandied as a major influence in coercive policy development. However, the schism in the movement reveals opposing approaches for disease control. John Macnicol's 1989 articles in the *Social History of Medicine* and the *Journal of the History of Sexuality* may have been helpful in this regard. Likewise, Joan Higgins work on comparative analysis in social policy from 1980 evinces the value of comparison as an important methodological tool for exploring what governments do or do not do transnationally. Then there are the many assassins of social control theory in the 1980s and 1990, who acknowledged that self-empowerment formed the basis of much social policy reform. Early narratives about the development of policy and process are referenced unashamedly. For instance, AMJ Henk's *The Growth of Medical Knowledge* (1990), John Brotherston's, *Observations on the Early Public Health Movement in Scotland* (1952), and Stanley Cohen and

1 Peter A Hall, "Policy paradigms, social learning and the state: the case of the economic policymaking in Britain, *Comparative Politics*, Vol. 25, No. 3, (April 1993), 280.

Andrew Scull's *Social Control and the State: Historical and Comparative Essays* (1983) are all given their due. The object is to incorporate into the narrative the literature that emerged prior, during, and after the period of most historiographical saturation. Recent contributions in the field include Anne R. Hanley's work on medical practice in England in the late nineteenth and early twentieth-centuries; Raden Dunbar's examination of venereal diseases in the context of the Australian military; and Daniel J. Walther's examination of race in the German colonial setting.[2] The hope here is that amongst the vast historiography of the social history of venereal diseases there is room for at least one more book.

2 Anne R. Hanley, *Medicine, Knowledge and Venereal Diseases in England, 1886–1916* (London: Palgrave MacMillan, 2017); Raden Dunbar, *Secrets of the Anzacs: The Untold Story of Venereal Disease in the Australian Army 1914–1919* (Melbourne: Carlton North Scribe Publications Pty Ltd, 2015); Daniel J. Walther, *Sex and Control Venereal Disease, Colonial Physicians, and Indigenous Agency in German Colonialism, 1884–1914* (New York: Berghahn, 2015).

ACKNOWLEDGEMENTS

The lion's share of the primary research for this book was done between 1996 and 2000. In that period, I was extremely fortunate to have had the support of many who went above and beyond the call of duty. First and foremost, I would like to acknowledge the Department of History at the University of Adelaide. I would especially like to acknowledge Adrian Graves, Robert Dare, Frank MacGregor and Roger Knight.

I was able to spend a year as a postgraduate student in the Department of Economic and Social History at the University of Edinburgh. I would especially like to acknowledge Michael Anderson, Roger Davidson, Mo Davidson, Gayle Davis, Helen Coyle, and Martin Taylor. The excellent staff of the following institutions also deserve a mention: the Mortlock Library Adelaide, the State Library of South Australia, Adelaide City Archives, the State Record Office of South Australia, the Barr Smith Library at the University of Adelaide, Mitchell Library of NSW, the Scottish Record Office, National Archives of Scotland, the Central Library in Edinburgh, and the National Library of Scotland.

For their moral support at the time and since, I would like to thank, Tania Jeffries, Helen Payne, Lesley Abel, Michelle Cunningham, Nona Verco, Akos Nagy, and Helen Atar, as well as the late Margo Tamblyn and Shirley Barlow. Despite all of the support I have received, any flaws in the book are entirely down to me.

ABBREVIATIONS

BMJ	British Medical Journal
BPP	British Parliamentary Papers
DHS	Department of Health for Scotland
EPHD	Edinburgh Public Health Department
GRG	Government Record Group
HCD	House of Commons Debate
HH	Home and Health Series
LGB	Local Government Board
LHB	Lothian Health Board
MiL	Mitchell Library of NSW
MJA	Medical Journal of Australia
MLSA	Mortlock Library of South Australia
MOH	Medical Officer of Health
NAS	National Archives of Scotland
SBH	Scottish Board of Health
SRO	Scottish Record Office
SAAP	South Australian Act of Parliament
SAPD	South Australian Parliamentary Debates
SAPP	South Australian Parliamentary Papers
SLSA	State Library of South Australia
SRG	Society Record Group
SRSA	State Records of South Australia
WCTU	Woman's Christian Temperance Union

INTRODUCTION

> By the study of anthropology, sociology, psychology and such elements of social and political economy as are relevant, we try to work out our correct principles to guide us in our approach to the social problems of the time. Nevertheless, the application of those principles to a given situation is an art.[1]

Venereal diseases, or at least the fear of them, literally spread across the world. Venereal diseases have, according to Claude Quétel, terrorised the most people, killed fewer people than tuberculosis, and were less feared than any psychosis but have also caused the blackest ink to flow.[2] Contemporary concerns about social morals and racial fitness underpinned many studies into social responses to venereal diseases. Measures to control venereal diseases incited considerable debate among liberal social reformers, the medical profession, public health authorities, and legislators. To remove venereal diseases policy reform from the auspices of public health policy also removes it from the history and analysis of social policy development. The conclusions of the historiography thus far seem to ignore the often complex and contradictory nature of human relations. Analyses that do not consider the possible implications of the interrelating issues risk being crudely reductionist. While the approaches to date have much to offer in aiding the understanding of anxieties and assumptions in the early twentieth century, historians appeared to use them in too rigid and deterministic a manner. Such an approach serves to "obscure rather than explain".[3] The popular explanations for the motivation and consequence of coercive health policy can be qualified when scrutiny is applied to specific experiences in particular circumstances. To interpret change in policy, or the introduction of a new policy, as the result of some grand design or as a

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1 Aneurin Bevan, *In Place of Fear* (London: Simon and Schuster, 1952), 35–6. Aneurin Bevan was the Labour politician who was the architect of the political compromises that established Britain's National Health Service in the 1940s.

2 Claude Quetél, *History of Syphilis*, trans. Judith Braddock and Brian Pike, (Polity Press: Cambridge, 1990), 2.

3 Philip J. Fleming, *"Shadow Over New Zealand": The Response to Venereal Diseases in New Zealand 1910–1945*, Ph D Thesis, Massey University, New Zealand (1989), 170, 199.

deliberate attempt to exercise control is not realistic.[4] Changing values, innovations in practice that facilitate policy development, and periods of extraordinary social conflict that require urgent responses are issues that are often found to be beyond the remit of social policy analysis in its purest form. The debates surrounding so-called protective and preventive legislation are most illustrative of the problems and prejudice associated with legislating on sexual matters.

The foremost goal of public health, then as now, was to prevent or minimise the impact of disease on a community. Historically, communicable diseases have posed the greatest threat to health. Public health officials used the tools of isolation, quarantine, and vaccination to combat these threats. Public health campaigns have sought to change people's behaviour in order to forestall bad health outcomes. These campaigns have historically used fear as a motivating force to highlight the dangers of engaging in certain practices. Public health goals of limiting morbidity and mortality can be examined from two opposing ethical frameworks: deontology and teleology. Deontology is more concerned with absolute moral foundations. The deontologist opinion holds that all public health measures must be grounded in moral certainties. The teleologist who focuses on outcomes contends that the ends can justify the means, but only if those ends are socially beneficial. Population-based disciplines, like public health, subsume the thoughts and wishes of the individual to the needs of the populace. This form of paternalism centres on the use of state power and authority to guide the behaviour of individuals. John Stuart Mill, an advocate of nineteenth- century political and social libertarianism, believed the state could not enforce its will on the governed without the permission of the governed. Although utilitarian ethics take into account the broader social betterment created by the improvement in individual health, the rights of the individual cannot be wholly ignored.[5]

The influence, or otherwise, of social organisations, institutions, and pressure groups on policy demonstrates that social policy may be better defined as a process of negotiation between various horizontal bases of power rather than as a reform strategy imposed exclusively from above. However, as John H. Mayer pointed out in 1983, working primarily to establish reformer

4 Joan Higgins, "Social Control Theories of Social Policy," *Journal of Social Policy*, (9) (1), (1980), 21.
5 Ishmeal Bradley, MD, "Ethical Considerations on the Use of Fear in Public Health Campaigns", in *Clinical Correlations,* NYU Langone Online Medical Journal, (23 November 2011).

motivation and then labelling reformers' efforts has obscured the meanings of particular reforms. Functionalist analysis of institutions utilise a rhetoric that suggests a primary concern to demonstrate the falseness of reformers' good intentions. Within the context of its times, a particular reform may have been seriously, sincerely, and realistically proposed because of a belief that habits of virtue and religion would lead to success or, at least, elevate one's life where vice would not degrade it. While methods of social policy development have been problem focused and pathology orientated, to Mayer a contemporary source of meaning in disease reform was the ubiquitous belief in the possibility of self-empowerment.[6] This has thrown up a paradoxical issue in the conflict between the "rights" and "needs" model for understanding social problems.[7]

A policy designed to change or maintain social structures or relationships could be described as social policy. The failure to make such policies can also be treated and analysed as a form of social policy.[8] Whether it is appropriate to include what governments *don't* do, in terms of specific policies to address a particular need, as well as what they *do* do is a question asked by some social policy analysts in the period of review.[9] What appears to be government inaction or non-decision may come to represent a considered policy when the government persists with a particular position over time against pressures to the contrary. The development of social policy has been most successful when societies have used traditional government levers such as legislation, regulation, or financing to achieve policy outcomes. However, attempts have often floundered when the policy levers have been aimed at persuading people to change their behaviour.[10] The complexity of the relationship between governments and the societies

6 John H. Mayer, "Notes towards a Working Definition of Social Control in Historical Analysis," in Stanley Cohen and Andrew Scull (eds), *Social Control and the State: Historical and Comparative Essays* (Oxford: Robertson, 1983), 20–22.

7 Rosemary Kennedy Chapin, "Social Policy Development: Strengths and Perspective," *Social Work*, Vol. 40. No. 4, (1995); Julian Rappaport, "In praise of paradox: a social policy of empowerment over prevention," *American Journal of Community Psychology*, 9(1) (1981), Abstract.

8 Paul Spicker, *Social Policy Theory and Practice Third Edition* (Bristol: Policy Press, 2014), 63.

9 Spicker, 17; A. Heidenheimer, H. Heclo and C. Adams, *Comparative Public Policy: The Politics of Social Choice in America, Europe and Japan*, 3rd edition, (New York: St. Martin's Press, 1990) 5; Norman Ginsburg, *Divisions of Welfare: a critical introduction to comparative social policy,* (London: Sage, 1992), 12.

10 Mary Ann O'Loughlin, Occasional Lecture for Australian Social Policy Association", presented on 11 March 2015, Australian National University, Canberra.

for whom they legislate and the influences or otherwise of social organisations, institutions, and pressure groups are important factors in this relationship. Compromise is frequently the outcome between the competing demands of interest groups.[11] This is the result of the constraints historical, economic, or political in nature, within which policy-makers are forced to operate and a quintessential feature of healthy, democratic societies. Social policy is concerned with the policy-making process, which has always entailed an element of intuition and creativity.

Around the same time as venereal diseases historiography reached prolific status, so did that of comparative social policy. However, the two rarely seem to have crossed paths. Some social policy theory and practice is inspired by the image of government steering society from above. Critics of this approach warn that government is not able to steer a society as a *dues ex machina* from a position above, thereby detached from the society it is trying to steer. Government is itself a part of the social system among the many social factors influential in public policy processes.[12] It has been argued that the overall advantage of comparison in social policy is that it permits the researcher to identify the social determinants of policy and to differentiate between culturally specific causes, variables, institutional arrangements, and outcomes and those that are characteristic of different systems and different countries.[13] Thus, comparative research is an important methodological tool for exploring key issues in social policy because it is more effective than one-country studies in identifying "what governments are not doing because we have a greater awareness of what they could be doing."[14] However, it must be said that social policy theorists tended to avoid the complication of historical time. By repositioning the social history of venereal diseases policy within the developments of social policy over time, one is able to shake off the deterministic approaches of the past and reveal a more complex and, indeed, more interesting history. This

11 Joan Higgins, "Social Control Theories of Social Policy," (1980), 14.
12 David Hazelhurst, Discussion Paper No. 83, (July 2001). This discussion paper is a revised version of a Policy Analysis Report written as part of the requirements for a Masters in Public Policy, Australian National University, 34.
13 Joan Higgins, "Social Control Theories of Social Policy" (1980), 12.
14 Joan Higgins, *States of Welfare: Comparative Analysis in Social Policy*, 17; See also F.G., Castles, *The Working Class and Welfare: Reflections on the Political Development of the Welfare State in Australia and New Zealand, 1890–1980* (Wellington: Allen & Unwin Port Nicholson Press, 1985), 22; Rob Watts, "Family allowances in Canada and Australia 1940–1945: A comparative critical case study", *Journal of Social Policy,* Vol. 16, no. 1 (1987), 22; Ginsburg, *Divisions of Welfare*, 24,

approach is useful for revealing the mechanisms that drive the social reform process where controversy is a distraction and reveals that in some societies on some issues it was more prudent to have a policy of not having a policy.

While Peter Baldwin's *Contagion and the State in Europe, 1830–1930,* and Milton Lewis' *Thorns on the Rose: The History of Sexually Transmitted Diseases in Australia in International Perspective* offer a comparative approach in the literature, they are too far ranging geographically and traverse too long a time span to constitute case studies in the usual sense.[15] However, as Lewis points out his perspective is quantitative rather than qualitative and, therefore, does not really address the intricacies and complexities of the venereal diseases policy debate in close detail. Aside from the statistical issues surrounding diseases infection rates, comparative methodology is an important methodological tool for exploring key issues in venereal diseases policy. The purpose is to distinguish the general from the specific, if only to identify what is "generally true" for all countries and what is unique and "specifically true" in any situation.[16] Comparison allows us to see the historical trends and pressures that are valuable for contextualising the national within the global and the local within the national. This methodological procedure is needed as it allows the historical process to reveal all of its inherent contradictions and guard against self-contained analyses that can be the disadvantage of the local case study approach. Comparative studies can demonstrate that single theoretical models are insufficient to understand the motives of authorities or the success, or otherwise, of schemes to control venereal diseases. Furthermore, popular explanations for the motivation and consequence of coercion may be qualified when specific experiences in particular circumstances are scrutinised. The controversy surrounding venereal diseases policy surfaced and resurfaced throughout a period of significant social change. This change, whether the result of war, economic turmoil, or the practical development of medical technology, is reflected in the debates and discourses surrounding venereal diseases. The most enlightening deployment of comparative methodology is to select societies that may be derived from a similar value system but respond to pressures indifferent ways. They may have a historical relationship that has evolved and diverged over time or they may have been informed by the same emergent ideologies

15 Milton J Lewis, *Thorns on the Rose: The History of Sexually Transmitted Diseases in Australia in International Perspective* (Canberra: Australian Government Publishing Service, 1998); Peter Baldwin, *Contagion and the State in Europe, 1830–1930*, (Cambridge: Cambridge University Press, 1999).
16 Janz and Daniel Schönpflug (2014), 1.

but have integrated them in social change to varying degrees. That is to say, they may be similar, but not too similar, or different, but not too different. The most useful point of discussion is the influence of culturally dependent states and to what degree any desire for autonomy affects social policy decision making. Whether autonomy means adoption of a particular policy or a concerted attempt to prevent it might be determined by constitutional arrangements or tradition. The examination of policy drivers and constraints can reveal social policy change determinants that are directed by ambitions to emulate, in some instances, and the determination to differ in others.

Sometimes the constitutional constraints within which governments operate demonstrate the difficulty of attempting to mould a national experience from a diverse set of circumstances. In the United Kingdom as a unitary state, political power is highly concentrated and subject to a range of conventions. The party with a majority in the House of Commons rules absolutely.[17] Scotland, Wales, and Northern Ireland have a degree of autonomous devolved power, but such devolved power is delegated by the Parliament of the United Kingdom, which may enact laws unilaterally. In Scotland, most people lived in Glasgow and Edinburgh. Social policy was determined by the Scottish Office in London, headed by the Secretary of State for Scotland. The Local Government Board for Scotland oversaw local government, public health, and poor law of Scotland from 1894 to 1919. The Board was established by the *Local Government (Scotland) Act 1894*. The *Public Health (Scotland) Act 1897 (60 & 61 Vict C38)* made the Board the central authority for public health in Scotland, thereby empowering it to carry out inquiries into the sanitary conditions of any district. The Board was abolished in 1919 and replaced by the Scottish Board of Health that was abolished and recreated as Department of Health for Scotland in 1928. Local government was reorganised by the *Local Government (Scotland) Act 1929*. Generally, local authorities in Scotland were less controlled by the central authority than is usual in England. In 1938, the Report of the Departmental Committee on Scottish Administration recommended that certain departments be merged. In 1939 the Scottish Education Department, Department of Health for Scotland, Department of Agriculture for Scotland, Fishery Board for Scotland, and the Prisons Department for Scotland were abolished as separate departments, and they instead became departments of the Secretary of State. While there was some divergence in policy, there were also limits on Scotland's autonomy. There was much indignation when Scottish attempts to establish policy of their own were thwarted by Whitehall. To the Scots, the local boards were in the best position to manage

17 Hazelhurst, Discussion Paper No. 83, (July 2001) 7.

local social problems without undue central interference. Health reforms, particularly those relating to the control of diseases, that had been laid down by central authority were against the principles of Local Government as it was accepted in Britain.[18] Local boards of health attempted to engage directly with the central government in order to develop policy relevant to local conditions. Despite the willingness of city corporations to pursue reforms for their own immediate jurisdictions, their proposals were sometimes seen as not practicable in the parochial context in which the reforms were to operate. The angst this generated was never far from the surface during the campaign for venereal diseases control in Edinburgh.

Prior to 1 January 1901, in political terms Australia was the sum of a group of fiercely independent and competitive colonies. When Australia became a federation, the people of the colonies agreed to "unite in one indissoluble Federal Commonwealth". The new federalism involved two tiers of government in which power was (and still is) divided between the Commonwealth and the States. Australian federalism was based on the idea the greater body of power should lie with the state governments. The framers of the Constitution intended that the new nation the states would be the dominant partner. By restricting the Commonwealth to specific areas from marriage to defense, the remainder, including health, was left to the states.[19] Informed by Australia's history and geography in matters of public health policy, this arrangement was determined to be the best option. The Royal Commission on Health took evidence between January and July 1925 and examined 320 witnesses. The terms of reference were "to report on public health as a matter for legislation and administration by the Commonwealth in conjunction with the States where necessary". The Royal Commission report alluded to the general policy of suspicion and distrust by the state governments in respect to the Commonwealth Government, where differences in policy have arisen. Health policy, the report said, had been affected by the "politics of the moment". It was "not likely", the report continued, that the Commonwealth Government would submit a proposal to amend the constitution to transfer legislative powers in respect of health to the Commonwealth unless a case for such transfer was justifiable. As public health administration in the states was so extensive and rooted in highly developed municipal and local arrangements, the Commissioners

18 E.E. Reynolds, *Ourselves and the Community* (London: Cambridge University Press, 1932), 24, 42.

19 Professor George Williams AO, "A Guide to Our Constitution." This is a paper presented at the National Archives of Australia in Canberra, Australia on 10 July 2011.

doubted whether the community would be advantaged by such a transfer. It was clear to the Commissioners that the organic unity between local government and state government would make Commonwealth legislation and administration impracticable.[20]

Despite the parochialism of the Australian states, colonial and state legislation often had its roots in British statutes. Policy development was at one time or another either informed by events in the mother country or driven by a determination not to repeat its mistakes. In 1837 George Stevens, secretary to the governor of South Australia wrote that what the colony wanted was,

> not the transcript of the English Statute Book; but well considered laws applicable to the state of society existing in our infant colony, unfettered by precedent; expressed simply, distinctly, and with no more words than necessary […] The pleas that they are not in unison with the practice of English courts ought to be thrown overboard at once.[21]

Australian legislators were selective in their adoption of British strategies for local use.[22] The development of health policy in Australia had evolved gradually from a system of private entrepreneurial philanthropy towards a service organisation funded and controlled by government.[23] The debate over public health issues in Adelaide revealed that, despite the British precedent on particular policy decisions, South Australian legislators attempted to lead rather than follow. While lessons could be learned from elsewhere, nationally or internationally, contingency and local public opinion were the directors of health policy.

Douglas Pike wrote in his social history of South Australia in 1957 that one objective of early settlers was to avoid homogeneity with the rest of the continent. While Adelaide exploited its neighbours' markets and gold, it refused to share their origins and ambitions. While it saw value for itself in federation, it clung tenaciously to state rights. To its people, South Australia was never a colony but an outlying English province with its own peculiar foundations and sense of nationalism. Its parochialism, Pike argued, was

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20 Royal Commission on Health, *Commonwealth Parliamentary Papers* 1926-28, vol. IV, 1247–1370.
21 George Stevenson quoted in John Cashen, "Masters and Servants in Early South Australia," *The Push From the Bush*, no. 6, (May 1980), 24
22 Anne Crichton, *Slowly Taking Control: Australian governments and health care provision 1788-1988* (Sydney: Allen & Unwin, 1990*),* 11, 13–14.
23 Anne Crichton, *Slowly Taking Control,* (1990), 7.

almost exclusive.[24] At the same time, many features of South Australia's colonial development were innovative, thereby incurring the epithet "paradise of dissent", which was coined by Pike and still resonates. One social commentator noted in 1883 that,

> Definite political parties, there are none, except on the few occasions when a stirring question has temporarily divided the community […] In most important reforms […] South Australia has either led the way or been amongst the first. Thanks to the more advanced views of the earliest settlers, the abuses to be done away with have never been so flagrant as in the other provinces. Hence, the work of reform has in every case been carried out in a more just and moderate spirit […] Reviewing Australian politics as a whole, one notices that whilst all the colonies are distinctly "liberal" in their ideas, the shades of colour vary from Whiggism […] to extreme Radicalism […] with South Australia as the exponent of the more sober Radicals.[25]

It was those more sober radicals that negotiated a way through the social policy reform enigma. After its proclamation as a free colony (no convicts) in 1836, South Australia initiated a number of democratic reforms. The care of destitute children (1866), industrial arbitration (1894), and female suffrage (1894) were all considered in South Australia before the neighbouring colonies. This history of going alone and going first was evident also in the development of venereal diseases policy.

Having established their constitutional credentials, the focus of this study is devolved from the United Kingdom and Australia to Scotland and South Australia. Both sought autonomy in issues they saw as affecting their regions. Adelaide and Edinburgh were the centres of government in their jurisdictions. As such, health authorities and legislators in these two cities attempted to establish public health policy that reflected local conditions and aspirations. This attempt at historical, comparative social policy analysis around venereal diseases policy hopes to reveal the reform enigma: that is, the machinations of the social reformers, legislators, health officials and community leaders who sought to inform the debate in two cities. From its original preoccupation with sanitation, the legal debate surrounding the issue of compulsion in public health in the United Kingdom and Australia quickly came to incorporate a debate between advocates for the protection of civil liberties and those who argued that the individual had a responsibility

24 Douglas Pike, *Paradise of Dissent: South Australia 1829-1857* (London: Melbourne University Press, 1957), 49–56.
25 R. E. N. Twopeny, *Town Life in Australia* (London: Eliot Stock, 1883), 162-63, 170–71.

to the common weal that overrode any personal inconveniences. The venereal diseases debate in particular was infused with related issues: such as the age of consent, prostitution, abortion, alcoholism, and mental deficiency. Rather than offering categorical justification for decisive measures for control, these perceived evils confronted social reformers with the question of what might be possible, practical, and ethical. The success or otherwise of campaigns for policy change for venereal diseases suggests that the process of control was frequently negotiated rather than predominantly ideologically driven. Policy makers were acutely aware of the consequences of policy change and that women were maybe disproportionately disadvantaged. The point is whether legislators set out to discriminate or whether this was an unfortunate consequence of the limited approaches to venereal diseases policy that were available to them at the time.

Focus on specific policy reforms and the social conditions that informed them reveals a negotiation between governments, professionals in the field, and the community in which they operate. Scrutiny of the venereal diseases control policy debate challenges the assumption that control is wielded from above without recourse to those who were controlled or, more precisely, their advocates. The examination of policy drivers focuses on the constraints to social policy change in the social, scientific, and political contexts. The ambition to exert autonomy in this process is illustrated in two case studies. This approach is useful for revealing the mechanisms that drive a social reform process when it is distracted by controversy.

PART I

CONTROVERSIES IN HEALTH POLICY

"we have two sections of the community-
the compulsionists and the non-compulsionists."[1]

It is generally the case that modern democratic governments, whether in federations or in unitary states, are responsible for law and order, infrastructure, health services, and education. Under its constitution, the parliament has the power to make laws, the government has the power to implement the law, and the legal system has the power to interpret the law. Despite the designation of the state's role in society, its progress is usually the result of a sustained dialogue infused with a catalogue of competing arguments: whether the reforms will be socially and politically palatable, whether the goal in sight is clear, and whether the measures put forward are capable of achieving the goal are all considerations for policy makers. As James Gillespie argued in 1991, the issue of state intervention in the provision of health services has been a source of conflict as the various levels of government vied for control.[2] Civil liberties and other issues of personal freedom were important factors in the development of health policy and vital to understanding the problems and complexities that faced legislators in the mid-nineteenth and early twentieth-centuries. The Scottish born and educated Pennsylvania state politician James Wilson coined the phrase "civil liberty" in a 1788 speech advocating the ratification of the U.S. Constitution. He said,

> We have remarked that civil government is necessary to the perfection of society. We now remark that civil liberty is necessary to the perfection of civil government. Civil liberty is natural liberty itself, divested only of that part, which, placed in the government, produces more good and happiness to the community than if it had remained in the individual. Hence, it follows, that civil liberty, while it resigns a part of natural liberty, retains the free and

1 R. S. Richards, Leader of the Opposition, "Venereal Diseases Bill," House of Assembly, *SAPD*, 18 December 1945, 1392.
2 James A. Gillespie, *The Price of Health: Australian Governments and Medical Politics 1910–1960* (Cambridge: Cambridge University Press, 1991), ix.

> generous exercise of all the human faculties, so far as it is compatible with the public welfare.[3]

This description implies that civil liberties should be protected only up to a point. When that point was reached, what could be done about it formed the basis of the debate.

In 1958, George Rosen, in his *History of Public Health*, pointed to two components of public health reform that form the major strands of the fabric of public health policy. One is the development of medical science and technology, as well as understanding the nature and cause of disease, as a basis for preventative action and control. The other, was the effective application of such knowledge which, he contends, depends on a variety of non-scientific elements that are basically political, economic, and social factors.[4] Such considerations have complicated the development of public health policy. Policy development, especially in public health, has given rise to scientific and public controversies. Whether fluoride should be added to public water supplies to prevent tooth decay, or whether parents should be legally obliged to vaccinate their children are two modern controversies. When a society is being obliged to change its behaviour or subject its self to control, such controversies often have profound social, political, and economic implications, and often feature in public disagreements by interest groups even where they are not represented among the aggrieved. By far the most important driver of social policy reform, or indeed its creation where none existed, is the appetite for reform and the source from which it draws its nourishment. Whether the confrontation occurs over the control of AIDS, about the proposed introduction of the abortion pill, or the control of venereal diseases prior to the availability of effective treatment, experts become involved in an advisory capacity in the policy development process. For policy makers, reliance on experts becomes increasingly difficult when disputes provoke major difficulties in decision-making for determining policy and negotiating the curse of implementation. The result is usually "vociferous, protracted, rancorous" debates, which ultimately remain unresolved. For example, some of the medical profession in Britain and

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3 Quoted in Tom Head, "Why Laws Exist", http://civilliberty.about.com/od/thebasics/ as at 14 May 2015; Penn Biographies, James Wilson (17421798), University of Pennsylvania Archives, http://www.archives.upenn.edu/people/1700s/wilson_jas.html accessed 14 May 2015.

4 George Rosen, *History of Public Health* (Baltimore: John Hopkins University Press, 1992), 85, originally published 1958. Also quoted in Dorothy Porter (ed), *The History of Public Health and the Modern State*, (Alanta: Rodopi, 1994), 1.

Australia in the early twentieth-century believed that sufferers of a venereal disease were not worthy of relief from their symptoms. This view incensed Havelock Ellis. In 1910 he wrote,

> I have […] even seen in a medical quarter their statement that venereal disease cannot be put on the same level with other infectious disease because it is "the result of voluntary action". But all the diseases […] are equally the involuntary results of voluntary actions…The instinct of sex is as fundamental as any […] and the involuntary evils which may follow the voluntary act of gratifying it stand on exactly the same level […] Any person who sees, not this essential fact but merely some subsidiary aspect of it, reveals a mind that is twisted and perverted; he has no claim to arrest our attention.[5]

While ideally experts offer "disinterested" advice, they serve to intellectualise a particular positon. Controversy arises when the experts are influenced by professional, economic, or political considerations.[6] Then they become involved not just as consultants but as committed proponents of a particular side of the policy debate. This is especially the case where said expert is also a politician. The influence of the expert can be diminished, or indeed dismissed entirely, where there is a failure to form a consensus within the body. For example, the medical profession may be accused of ambivalence towards compulsion as a strategy for controlling venereal diseases. However, it may equally be argued that any differences of opinion within the body were just that, not uncertainty, or indecision, but an indication of a more disparate membership with competing priorities. In the midst of this, it is the job of policy architects to decipher the moral argument from the efficient, practical, and defensible one. These issues are usually fought out, from a distance, in boardrooms and cabinet offices. The controversy begins when they are fought out in public. From the nineteenth-century, the conundrum of how to deal with the afflicted individual merged with the imperative to protect the healthy majority. Then the role of government developed from a provider of services to that of a public health administrator. Preventative strategies that raised the level of intervention by the state were a part of the evolution of public health policy away from purely sanitary reform. The appropriate level of intervention and the

5 Havelock Ellis, *Sex in Relation to Society* (London: WM Heinemann Medical Books Ltd, 1945 edition), 210.

6 Brain Martin, Evelleen Richar, "Scientific knowledge, controversy, and public decision-making", in Sheila Jasanoff, Gerald E. Markle, James C. Petersen, and Trevor Pinch (eds.), *Handbook of Science and Technology Studies* (Newbury Park, CA: Sage, 1995), 506–526.

maintenance of professional autonomy among interested groups were the points of contention throughout this period. Medical responses to public health issues merged with moral responses that were often injected with pseudo-scientific prescriptions for national fitness. Real and imagined social evils inspired debate on the evolutionary process and called for new scientific methods to stem racial degeneration. The "science" and practice of improving hereditary characteristics in man was thought to address the problem of racial degeneration at its source.[7] These controversies made the administration of health policy in the late-nineteenth and early twentieth-centuries the most "hotly contested" area of social policy. The argument over compulsion in the notification and treatment of venereal diseases drew on a long history of debate on the role of compulsion in public health. Determining influence of this precedent in developing public health reform in the control of venereal disease is the purpose of Part I. How did historical controversy affect policy development in public health generally and venereal diseases in particular?

7 H. S. Jennings, "Eugenics", in Edwin R. A. Selwyn & Alvin Johnson (eds.), *Encyclopaedia of Social Sciences*, vol. V (New York: Macmillan, 1931), 617.

CHAPTER ONE

"CITY OF STENCHES"

> It is generally admitted in all civilized countries, and indeed is the reason for constituting a separate department of medical instruction under the name Medical Police, that the prevention of disease on a large scale may often be in the power of a community, although beyond the power of many on the inhabitants composing that community.[1]

Given the constitutional arrangements between England and Scotland with regard to the legislative and administrative histories of public health, one would expect consistency in both content and chronology. However, Scottish social legislation in the nineteenth-century followed well behind the developments in England. An important part of the reason for this was the controversy around from where diseases sprung and how they were spread. Many English experts among medical profession favoured miasmatic thought as a cause of diseases and the removal of material likely to produce "malarias" was the solution. Up to the late 1840s, miasmatic thinking dominated medial research and public policy. For miasmatists, the virtue of medical knowledge was not in its truth because the practical knowledge was very effective in some cases. At least it could not be discredited by a generally accepted theory based on scientific knowledge. The counter argument was "contagionism" that was based on primarily theoretical knowledge which, at this early stage, lacked the methodological proof that contagion was their direct causes. Contagionism and miasmatism were associated with a growing body of knowledge that was theoretical and practical, respectively, but was, neither in theory or practice, successful in changing the popularity of both thought-styles.[2] It was in the *Report of the sanitary conditions of the labouring population of Scotland* of 1842 where a discussion surrounding what to do about the public nuisances in Edinburgh began in earnest between miasmatists and contagionists. The

1 W. P. Alison, *Observations on the Management of the Poor in Scotland and its effects on the Health of the Great Towns*, (Edinburgh: William Blackwood & Sons, 1840), x.

2 Henk A.M.J., *et al* (eds), *The Growth of Medical Knowledge*, (Dordrecht: Kluwer Academic Publishers, 1990), 28.

surgeon, William Chalmers, reported Edinburgh to be "one of the most uncleanly and badly ventilated in this or any adjacent country". The "excrementitious matter of some forty or fifty thousand individuals" was thrown daily into the gutters or poured into carts. In the narrow and worse ventilated closes, throwing out every kind of liquid refuse was prevalent. Epidemics, he claimed, diffused most rapidly in the overcrowded closes of the High Street and Canongate, the Pleasance, West Port, Grass Market, St Leonard's Street, the Cross-causeway, and some parts of the Causewayside. He believed that filth and bad ventilation propagated fever and poor nourishment, unemployment, deprivation, and the consequent mental depression; although he also argued that while it did not produce the continued fever of Edinburgh, it was responsible for diffusing it. The only effective and practical means to stem fevers would be to improve the state of the poor. With better food, clothing, housing, improved ventilation, abundant water, and provision for adequate sanitation, there would be the "discontinuance of foetid irrigations and any other nuisance generating malaria".[3]

Alison led the contagionist argument. In a thinly veiled criticism of the Poor Law Commissioners, Alison pointed out the belief by the Commissioners that the original cause of contagious disease was a "malaria arising from putrescent animal and vegetable matters, and from excretions from the human body". Alison believed a much better prospect of preventing the introduction and spread of a disease in Edinburgh was through better-managed provisions to prevent destitution than by measures directed merely at the removal of those nuisances. On this point, the Commissioners questioned Alison whether destitution without the filth, or the filth without the destitution, was more effective in the spread of disease. He responded that this "hardly admits of a direct answer" as "we have not destitution without filth; but we have many examples of filth without destitution". Alison believed that contagion acts most rapidly on the human body when "enfeebled by deficient nourishment, by insufficient protection against cold, by mental depression, by occasional intemperance, and by crowding in small ill-aired rooms."[4] Alison chose not to enter into the misamatist debates as to whether the effluvia arising from putrescent animal and vegetable matter could produce fever. The question, he argued, was whether the

3 Alexander Miller, Surgeon, *Report of the sanitary conditions of the labouring population of Scotland*, (London, W. Clowes & Sons, 1842), 157.
4 W. P. Alison, "Observations on the Generation of Fever", *Report of the sanitary conditions of the labouring population of Scotland* (London: W. Clowes & Sons, 1842), 25.