

“The Cinderella of Medicine”: sexually-transmitted diseases in Britain in the nineteenth and twentieth centuries

Lesley A Hall

The British approach to the problems of venereal diseases has been characterised by reluctance to engage with the issues, intermittently punctuated by panicked flurries of demonstrable if not always efficacious activity generating overt controversy, such as the Contagious Diseases Acts of the 1860s. Nevertheless, the system of free confidential “open door” clinics established in 1917 proved highly effective in spite of grudging resources and stigmatization. The epidemiological picture had altered radically by the early 1950s, with syphilis, once endemic, nearly eradicated, but persistent attitudes were activated once again by the advent of AIDS in the 1980s.

Historically, the principal sexually-transmitted diseases in Britain have been syphilis and gonorrhoea. Chancroid was prevalent until the early twentieth century, while a small number of more exotic infections entered from tropical parts. During the twentieth century increasing sophistication of diagnosis within specialised clinics has identified other genitourinary diseases.

In 1865, Samuel Solly, President of the Royal Medical and Chirurgical Society, declared that syphilis was “intended as a punishment for our sins and we should not interfere”, a “Victorian” attitude towards venereal sufferers widespread well before the Queen’s accession. The actual prevalence of venereal diseases in the Victorian period is hard to establish: hospital recordkeeping could be inaccurate, and Poor Law Commissioners’ Reports did not enumerate venereally-diseased paupers admitted to workhouses.^{1,2}

Most hospital cases were treated as outpatients. A very few Lock hospitals specifically for venereal patients existed: other hospitals might allocate a few beds for VD cases, only admit patients under special conditions (such as innocent infection), or simply refuse admission.¹ Such restrictions were generally not applied to patients with late syphilitic manifestations.³ By 1857, in London (population 2.5 million) there were 297 beds specifically for venereal patients. In 1854 an estimated one in 14 of the London poor demanding medical attention did so for venereal disease. In a population of 21 million there may have been 1.6 million cases of syphilis, perhaps more.¹

Only a proportion of cases even approached hospitals; those who could afford private medical care would do so, while others from poverty or shame sought assistance from quacks or treated themselves.³ Quacks

offered secrecy, rapid cure at moderate expense (even “No Charge unless Cured”), and without mercury (a cure perceived with considerable justification to be almost worse than the disease).^{3,4} Those who underwent such treatment were not necessarily infected; medical journals continually fulminated against the stimulation by “advertising quacks” of chimerical anxieties upon which they traded.^{3,5}

In spite of the claims of the medical profession to authority over treating venereal diseases doctors displayed much vagueness and uncertainty. Gonorrhoea and syphilis had been recognised as distinct, and syphilitic differentiated from simple sore. The existence of innocent, as well as of hereditary, infection was recognised. Syphilis was known to lie quiescent for years, infiltrating the bodily tissues, but ascertaining whether secondary and tertiary syphilis would eventuate from a primary sore was not easy. Mercury remained the principal therapeutic weapon, administered with a heavy hand, leading to the terrifying consequences of severe mercurial poisoning. It did not guarantee cure; relapse always threatened, and sufferers were advised to postpone marriage. Iodide of potassium, introduced in 1836, was especially used in tertiary stages. Gonorrhoea was taken less seriously: while some physicians still treated it with mercury others instilled caustic solutions into the urethra, applied lotions, or dosed patients with copaiba, balsam and cubebs. In acute cases cauterisation was resorted to. As with syphilis, cure was pronounced on the disappearance of external symptoms. Simple sores were subjected to localised caustic treatment.¹

The approach of British doctors rested upon clinical observation: one of the few notable eponyms in venereology derived from a Briton is “Hutchinson’s triad” indicative of congenital syphilis. There was little interest in experimental work as performed by Ricord; most advances in knowledge derived from the continent. The microscope was rarely used in investigation, and the speculum gained ground slowly in the face of moral reservations. Venereal diseases were discussed in medical periodicals, increasing numbers of textbooks for the profession were published, but facilities for formal study were few, hindered by continuing stigma.¹

Demands for preventive measures in the Chadwick era of sanitary reform were problematic. Was the disease just punishment for a moral lapse, the understandable outcome of

male human nature, a fact to be dealt with emotionlessly for its better eradication? Theories about transmission suggested the efficacy of ablution after intercourse, but it is unclear whether this was widely recommended.¹ Class, religion and other factors influenced views for and against controlling the disease through control of prostitution.

Conflicting views over venereal disease control came into the open with the passing of the Contagious Diseases Acts, 1864, 1866, 1869. These should be seen in the context of Victorian debates about prostitution, "The Great Social Evil". By the 1860s these discussions were expressed in medicalised rather than purely moral terms: prostitution seen as ineradicable but containable in the interests of society.^{6,7}

The Acts were motivated by anxiety over the fitness of the country's armed forces. Syphilis in the forces had been increasing; by 1863 one-third of sick cases was venereal. The Government had already promoted establishment of lock hospitals in naval ports.¹ Parliamentary debates unthinkingly assumed male licence as well as stereotyped perceptions about "brutal and licentious soldiery". The Acts were justified as relating only to the exceptional conditions of military life: soldiers were detached from normal domestic ties by the nature of their calling, a mere 6% permitted to marry "on the strength". Yet attitudes to troops as "the scum of the earth" were becoming modified; while soldiers' quarters were often extremely squalid, in 1857 the Royal Commission on the Health of the Army considered periodical genital examination of soldiers deleterious to their self-respect.^{6,7}

The initial 1864 Act, passed late at night in a very thinly attended house, supposed by many (including allegedly the Queen) to relate to veterinary rather than human disease, was to run initially for 3 years in 11 designated port and garrison towns (increased to 18 in 1866). Suspected prostitutes could be arrested, examined, and if infected with VD, forcibly hospitalised until "cured".⁶ The Acts lacked unanimous support even among the medical profession and sanitarians, and offended religious opinion as well as a range of interests from civil libertarians to early feminists. The repeal campaign active by 1870 involved wider moral and social issues of which space does not permit discussion. The Acts were finally suspended in 1883, and repealed in 1886.^{6,7}

The Acts aimed at reducing the military and naval venereal disease (VD) problem by providing a healthy prostitute population in the designated districts. In spite of early claims of success, and agitation for their wider extension, even to the civil population, the effectiveness of the Acts is highly questionable. Even if the diseases had been controllable by policing solely female partners in the commercial sex transaction, the state of diagnosis and treatment of VD at the time was inadequate. Detecting VD in women was hit and miss: few competent and conscien-

tious practitioners sought the position of examining surgeon, and the time allocated to instrumental examination of suspects rarely sufficed for accurate diagnosis. Many infected women must have eluded detection, while others with harmless vaginal discharges were incarcerated.^{6,7}

Given these vagaries of diagnosis, and the dubious effectiveness of treatment, statistics generated under the Acts are highly suspect. Even within their own terms it would appear that the Acts were not as successful as their advocates had anticipated. Among the civil population the incidence of VD was declining from the 1860s while the health of the forces was improving as a result of general sanitary reform. Slightly reduced rates of primary syphilis among troops, and the minor associated saving, were dearly bought by a cumbersome and unpopular system.^{7,8}

An alternative system of control was pioneered in Glasgow and taken up by other Scottish and English cities. The still new municipal police force was granted special powers over brothels and soliciting, in alliance with powerful philanthropic "rescue" institutions enforcing speculum examination as a condition of entry. Successfully reducing prostitution's public visibility, and possibly its prevalence, the efficacy of such measures as disease control was dubious for both medical and social reasons.⁹

Most voluntary hospitals continued to ban the venereally diseased. Friendly Societies would not pay sick benefit for venereal afflictions. Sufferers, rich and poor, to conceal their disgrace or deluded by advertisements, sought treatment from chemists or herbalists.^{3,10,11} Medical practitioners shrank from private practice in venereology, profitable though it was. Although wards full of patients with the hideous manifestations of tertiary syphilis were not uncommon, medical students learnt little of VD and might never see a case.¹²⁻¹⁵

Mercury was still the drug of choice in syphilis, if the horrendous salivations of earlier years had gone out of favour. Treatment for gonorrhoea varied from the lackadaisical recommendation, presumably by private practitioners, of syringing with a prescribed lotion, to violent instrumental assault and caustic instillations by public clinics and in army practice: a long-drawn-out and painful process sometimes more damaging than the disease itself.^{12,16,17} Soft chancre was prevalent and troublesome, though ferocious treatment could cause rather than cure the suppurating buboes associated with the condition.¹⁸

Folk myths about venereal diseases persisted: most noxious, that they were curable by intercourse with a virgin, persisted well up to the Second World War.¹⁹⁻²¹ In 1943 the Mass Observation survey for the Government on venereal diseases was told "to get rid of this disease they go out and find a young innocent girl to rape, who takes it from them".²² Such beliefs perhaps lingered because of the secrecy and shame particularly shrouding VD.

The long latent periods and insidious

nature, and hereditary transmission, of syphilis had long been recognised, and morbidity arising from it perceived as a national problem prior to the discovery of the causative organism and the rise of the Wassermann diagnostic test in the early years of the twentieth century, finally confirming the syphilitic nature of conditions arising years after infection. Gonorrhoea, though apparently less serious, was almost certainly more widespread, and was a major cause of sterility. In 1909 "Dr Ehrlich's magic bullet", the arsphenamine drug Salvarsan, supplied a cure for syphilis.³

From the 1890s, though without success until this therapeutic revolution, medical and philanthropic interests persistently attempted to generate government enquiry (preliminary to any further activity) into the problem of VD, which they were convinced was much underestimated. Succeeding governments, however, reluctant to tangle with what had proved already a political hornets' nest, were influenced by arguments that VD was in fact in decline; to be fought, if at all, through moral and religious measures. The issue was persistently "pigeon-holed", although committees and commissions on issues of national well-being indicated the seriousness of, and made suggestions about, the VD problem.²³ The Local Government Board instituted an inquiry in 1912, undertaken, however, by an officer who also had other duties.^{24 25}

Those seeking action were mostly opposed to any reintroduction of the Contagious Diseases Acts, expecting any scheme for checking the spread of these diseases to include men, on grounds of both justice and efficacy. They emphasised protection of the innocent: it is unclear if "innocent" infection (marital or acquired otherwise than by illicit sexual intercourse) was truly widespread, or whether it was hoped to counteract the stigma hindering discussion of, and provision of facilities for, VD control.²³

In 1913, since politicians and Government departments refused to be moved, it was decided to appeal to the "man in the street", with well-known individuals plainly stating the facts in the press. Open discussion and agitation for an inquiry followed. The 1913 International Congress meeting in London passed strong resolutions, and when Parliament next rose the Prime Minister announced the appointment of a Royal Commission.^{3 23} The timing surely owed much to the therapeutic optimism generated by Salvarsan.¹⁴

The Royal Commission (1913–1916), chaired by Lord Sydenham, heard evidence about the prevalence of the "terrible peril to our Imperial race", and existing provisions, as well as listening to recommendations. Reliable statistics of incidence proved almost unobtainable: an estimated 10% of the urban population had syphilis and an even greater proportion gonorrhoea; both appearing much more prevalent in males than females. British medical practitioners failed to appreciate the significance of venereal diseases and were

largely unfamiliar with new methods of diagnosis and treatment, thus the Wassermann test and Salvarsan had not fulfilled hopes.^{3 25} The Commission concluded that only State action could adequately deal with the problem. Universality of provision and its acceptability to the infected were emphasised: traditional stigmatising and punitive attitudes to sufferers were to be abandoned, as was discrimination by sex or class.³

The Commission's recommendations were implemented in 1916 through Local Government Board Regulations under existing Public Health legislation, and the Public Health (Venereal Diseases) Act of 1917. A nationwide system, free, voluntary, and confidential, was to bring sufferers and adequate expert treatment together. Administration of Salvarsan was restricted to authorised trained doctors, and the purveying of purported remedies by any but qualified doctors criminalised.^{26 27} The Government subsidised the National Council for Combatting Venereal Diseases to undertake the education about the diseases and their prevention, an enterprise recognised as a necessity.²⁸

While the Royal Commission was sitting, World War One broke out. Facilities for early diagnosis and treatment of VD in the forces were placed under considerable stress.¹³ Though relative numbers of cases compared favourably to prewar figures absolutely, larger numbers of men were involved, with 400 000 cases of VD in troops treated between 4 August 1914 to 11 November 1918. Gonorrhoea accounted for 66% of cases, syphilis around a quarter.²⁹ Means of reducing the prevalence of venereal diseases among the troops varied: exhortations to sexual continence, provision of licensed brothels (particularly in France), facilities for early ablution after exposure, the issue of prophylactic packs for self-disinfection. Medical officers' training improved, but vast differences between individuals remained.^{13 28–30} In 1916 an Advisor in VD to the War Office was finally appointed.¹⁵ The detection and treatment of large numbers of cases among forces personnel initiated radical decline in the incidence of syphilis.^{15 18 31}

Growing discussion of the subject, both as a civil national problem and as a specific military one, focused on the question not merely of the provision of treatment, but of prevention. During the War a Regulation under the Defence of the Realm Act (DORA 40d) provided for the forcible removal for treatment of any woman known to be a source of infection.²⁸ There were attempts to make the communication of venereal disease a crime under Criminal Law Amendment and Sexual Offences Bills being debated in Parliament, although these failed.³²

The National Council for Combatting Venereal Diseases (NCCVD), consisting largely of members of the Royal Commission, was reluctant to advocate prophylaxis for venereal diseases, as liable to encourage immorality, although provisions for early treatment after a lapse were acceptable and

desirable. Considerable and heated debate spilt over from the columns of medical journals into the lay press, and led to the formation of a Society for the Prevention of Venereal Disease (SPVD) which lobbied for the dissemination of information about, and facilities for, self-disinfection. The NCCVD, however, retained its prime position as the only organisation in the field approved by the Ministry of Health. Lord Trevethin's Committee in 1923 failed to come down firmly on either side or produce a viable compromise. The SPVD failed to challenge the NCCVD's favoured position with the Ministry, given the Ministry's disinclination to entertain a potentially contentious issue like prophylaxis. The feared explosion of venereal infections in the aftermath of the War did not take place, and their incidence perceptibly declined. The clinic system was seen to be working. The debate died down. The NCCVD moved into broader issues of social hygiene, changing its name to the British Social Hygiene Council in 1925.^{16 28 31}

After the War Colonel L W Harrison (formerly Advisor to the War Office) was appointed Advisor on Venereal Diseases to the Ministry of Health, and also took charge of a model VD clinic at St. Thomas' Hospital.¹⁵ Under his guidance, clinics were established within hospitals (rather than as separate institutions), to undertake teaching and research as well as treatment.³³ The "Harrison" system combined exacting standards of professional care with humane concern for the patient; Harrison himself was dedicated to the concept of a voluntary service working by making itself acceptable (if it could never be actually attractive) to the patient. He sought to achieve guaranteed confidentiality, convenience of access (including lengthy opening hours), and respect for sensitivities about privacy, as well as more humane methods of treatment.^{12 15}

In spite of the increase in infections resulting from the War, and inflation of figures through improvements in recognition and recording, VD declined perceptibly during the early 1920s; registered deaths from syphilis declined dramatically between 1918 and 1924. By 1919 over one million patients a year were seen by venereal clinics and attendances increased remarkably from 1917 to 1925, presumably due to improved facilities, and wider publicity.^{16 31} Between 1920 and 1923, attendances rose by over 100 000, while actual cases fell by 30 000.³⁴ Changing social mores doubtless played a part in this decline.^{31 35} By 1925 there was a network of 193 clinics throughout the country, funded 75% from central government sources, administered by local authorities as part of public health provision.^{13 31} Some doctors and officials, however, particularly in Scotland, believed this voluntary approach inadequate, and argued for greater legal powers over the recalcitrant infected.³⁶

The staffing needs of this network of clinics, requiring competence in demanding technicalities of diagnosis and treatment, led to

the development of a specialist cadre of medical officers with particular interest in the venereal diseases.³³ The Medical Society for the Study of Venereal Diseases was founded in 1925 with a membership of 293,³⁷ but the "pox doctor's" traditional stigma remained, in spite of new scientific developments. Clinics were assigned to cramped premises lacking laboratory facilities, providing inadequate privacy.^{15 38-40} Consultants in other specialities refused to be associated with them.¹⁵ Administrators appointed doctors lacking appropriate qualifications and imposed excessive segregation measures. Nursing staff could be sanctimoniously obstructive, while male VD orderlies were barred from State Registration as nurses.^{41 42}

Nonetheless, although some sufferers still resorted to chemists and quacks in spite of the restrictions upon their activities,⁴³ the system was extensively patronised by those suffering from venereal disease (or fearing they did). Most known syphilis cases were treated through the clinics:⁴⁴ annoyed venereologists in private practice alleged that they faced ruin as even those who could have afforded private treatment flocked to the free clinics.⁴⁵

Induced fever therapy for late neurosyphilis, developed during the 1930s, led to great reduction in cases of General Paralysis of the Insane.⁴⁰ In 1937 the introduction of sulphonamides revolutionised the treatment of gonorrhoea. They were also effective in chancroid, the incidence of which was already declining remarkably for reasons which are obscure, perhaps the result of better general hygiene.¹⁷ It seemed as if venereology as a speciality might soon disappear,⁴⁶ as many patients returned to private practitioners.^{42 47} The problem of resistant strains soon tempered initial optimism.⁴⁸⁻⁵¹ By 1939 under 5000 early cases of syphilis were seen in clinics, a fall of over 45% since 1931. Congenital syphilis was declining steadily, probably due to efforts in ante-natal clinics.^{42 48} The most radical break-through in treatment, however, was penicillin, with its major advantage of reducing treatment time, introduced in 1944, though its allocation for treatment of VD met initial prejudice.^{50 51}

Rates of infection rose rapidly on the outbreak of war. Planning proved inadequate and in spite of existing mechanisms VD in the armed forces was still the most difficult of diseases to control. Theoretically information was disseminated to all servicemen about risks and provisions for treatment but many denied receiving any such lecture. Measures of prevention and treatment were introduced: condoms issued, educational films shown, lectures given and poster campaigns initiated. With antibiotics many cases could be treated in units or the field.⁴⁹⁻⁵¹ The diseases were also a problem in the civil population. In 1943 regulation 33B under the Defence (General) Regulations provided for notification of carriers: not overtly discriminatory, it bore more punitively upon women.⁵²

Responsibility for anti-venereal propaganda under the Ministry of Health was

removed from the British Social Hygiene Council and entrusted to the Central Council for Health Education.⁵⁵ A publicity campaign to increase public awareness was inaugurated, partially breaching taboos on press or radio mention of the diseases,⁵⁴ though squeamish newspapers altered the forthright "pox" and "clap" used in initial versions of advertisements to vaguer, less demotic, terms.⁵⁵ The Mass Observation Survey for the Government, 1942–1943, revealed widespread ignorance and misconceptions about VD, its effects, and mode of transmission, some months after the inception of this campaign.²²

The more social approach to the VD problem evolving throughout the 1930s developed further under wartime pressures, and "contact-tracing" by trained social workers increased. Psychology of the "defaulter" from treatment and of the reinfected patient became of interest. Such patients were newly defined as neurotic inadequates.^{56–59} Another problem surfacing again and more acutely during the Second World War was "the problem of the amateur": women spreading VD were no longer only professional prostitutes,^{58 60 61} who were supposed, on rather spurious evidence, to be able to take care of themselves, unlike "amateurs".^{62 63} Even so, a popular solution persistently recommended to Mass Observation was licensed brothels (the rise in VD along with generally declining moral standards was not infrequently attributed to American GIs).^{22 64}

Numbers of infections peaked in 1946, to decline steadily throughout the 1950s with increasing availability of effective treatments through the comprehensive service consolidated by the introduction of the National Health Service in 1948, and run locally by regional hospital boards and boards of governors. Within ten years new cases of syphilis had declined to under 5% of the 1946 peak. Mortality from late syphilis declined, as did congenital syphilis.^{46 65}

By the early 1950s venereal infections were assumed to be "These Dying Diseases". Existing services were therefore starved of funds and facilities. The subject began to erode once more from the standard medical curriculum; a whole generation of venereal specialists was ageing and potential replacements were few. The diseases themselves were not dying: gonorrhoea was increasing ominously by the mid-fifties, especially among younger age-groups, partly due to emergence of resistant strains (the influx of immigrants and their associated social problems were also blamed). Non-specific urethritis, only recorded since 1951, showed steady increase: with initial effects (especially in women) mild enough to be often overlooked, its long term consequences appeared more sinister. While the diseases themselves were not receding as much as popularly imagined, the specialised staff and facilities for their treatment did seem endangered.^{46 66} As early as 1952 the British Federation Against the Venereal Diseases was set up to investigate

problems still outstanding, disseminate information and encourage good practice.⁵³

This rise in incidence was reflected, however, world-wide and was of lesser degree, and better contained, in the United Kingdom. In spite of the difficulties British venereologists faced in the post-war era, by 1976 an American venereologist could claim that "leadership in the broad field of sexually transmitted diseases has become centred in the United Kingdom."³³ The first chair of genitourinary medicine in the world was established in London at the Middlesex Hospital in 1980.¹³

The overall picture of sexually transmitted diseases had changed radically since 1917. The classic venereal diseases of syphilis, gonorrhoea and chancroid accounted for under 15% of cases seen in clinics, though unremitting increase in gonorrhoea caused continued concern. A wide range of diseases of the genitourinary system, not all venereal, were treated, with a high percentage of patients requiring no treatment. The "open-door" policy of British VD clinics brought in patients wanting advice or reassurance about genital problems or sexual difficulties which they hesitated to take to their general practitioners.^{5 13}

It was against this background of VD being apparently no longer a deadly menace to personal or national well-being that AIDS appeared in the early 1980s, initially in reports from the USA. Old fears (combined with popular and media homophobia) were transferred to this new menace: terror of innocent infection through lavatory seats or shared utensils, revulsion from doing anything for sufferers from a supposedly "self-inflicted" ailment. Demands that "something be done", conflicts over the form and content of health education, tensions between Government and voluntary organisations, recapitulated recurrent themes in the history of STDs in Britain.⁶⁷ There have even been suggestions that prostitutes be licensed and regularly inspected, although so far the UK has been spared the ravages of HIV seen in the USA or Africa, and heterosexually transmitted cases still form a small percentage.

The characteristic British response, or lack of it, to venereal diseases has not been, historically, all bad. Masterly inactivity had its points when diagnosis was uncertain and treatment dubiously efficacious. The conflicting interests of the interventionist school and the religio-moral lobby moderated extremes of policy proposed by each, and the resulting system epitomised British compromise, with its strengths and weaknesses. The system set up following the Royal Commission worked well in getting treatment to the afflicted, and no system of genuine efficacy could, it should be borne in mind, have been instituted very much earlier. This system continued to function effectively—though strained by the war years—even during post-World War II neglect, as comparative venereal statistics for Britain demonstrate. Anything to do with sex in the UK has always been a political hot

potato, avoided when possible, at other times panicking authority into demonstrable, though not always efficacious or appropriate, activity.

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