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“Sex Prejudice” and Professional Identity: Women Doctors and their Patients in Britain’s Interwar VD Service

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Abstract:
The 1920s witnessed a radical approach to sexual health in Britain, and women doctors quickly capitalized on the opportunities offered by the new VD Service. Because venereology was considered to be low status, it was among the few interwar specialisms that offered footholds to women. In view of the long-standing aversion to female engagement with subjects like VD, the large numbers of women doctors entering the VD Service seems puzzling. But as this article reveals, their clinical work was facilitated by rapid shifts in social and medical attitudes towards the treatment of VD as well as the role of women in public life. By exploring how these women navigated the shifting terrain of interwar public health, it deconstructs the notion that venereology was principally a male sphere of clinical practice and research. Moreover, it presents an important counterpoint to the narrative of women’s bodies subordinated to male medical authority. Although the individual lives of these women remain frustratingly elusive, a prosopographical study of their careers allows us to chart their professional networks and clinical activities. We can see how they appropriated prevailing moral codes and styled themselves as guardians of the nation’s health. At its heart, this article demonstrates how women established identities within a profession that remained inherently masculine. Moreover, it opens up new perspectives on the provision of care and the gendered politics of sexual health in a period of profound economic and social change.

In 1921, Lydia Henry, the first woman medical graduate of University College Sheffield, was appointed Assistant Medical Officer of Health for Blackburn, Lancashire. But, as she later reflected, the role involved much more than its title suggested. The newly established Ministry of Health had inherited responsibility from its predecessor, the Local Government Board (LGB), for developing a nationwide scheme to combat venereal diseases (VD). Henry was among its first female recruits. As a medical officer in the new VD Service, she was tasked with establishing a female clinic that would provide systematized, up-to-date care on an unprecedented scale.[1]

Women's clinical work has only recently begun to receive as much attention as that of their male colleagues. To the extent that they exist, histories of women doctors have traditionally concentrated on the first generations who, during the nineteenth century, forced their way into the profession.[2] Naturally, the focus has tended to be on the experiences of students and new graduates.[3] In view of the lingering Victorian distaste around women engaging with subjects like sex and VD, the large numbers of women entering the interwar VD Service seems puzzling. But as we shall see, their venereological work was facilitated by rapid shifts in social and medical attitudes towards the treatment of VD as well as the role of women in public life. By exploring how women like Henry navigated the shifting terrain of interwar public health, this article deconstructs the notion that venereology was principally a male sphere of clinical practice and research. It also presents an important historiographical counterpoint to the narrative of women's bodies subordinated to male medical authority.

The limited availability of archival data presents a problem for such a study. Surviving records from the VD Service shed light more on its establishment and administration than the experiences of patients and medical staff. Detailed information concerning doctor–patient relationships would have been found in the clinics' case notes. Unfortunately, few such records remain. In the absence of this rich narrative detail, we must rely instead on clinics' admission ledgers, medical periodicals, institutional records and advice manuals.

Individual case studies are rather thin, with the life of each woman remaining frustratingly elusive. Moreover, an account that drew heavily on the experiences of only a small number of individuals would be apt to mislead because clinics developed in unique ways, particularly in the early interwar years, when the VD Service was taking shape. Any generalizations therefore need broad foundations. These factors favor the application of prosopography—a fertile approach to social history. Through a *composite* study of women VD MOs working within the mixed economy of interwar healthcare, a rich picture emerges of their professional networks, clinical activities and relationships with patients.[4] Although prosopography has most commonly been used for records amenable to quantitative analysis, source constraints ruled out such an approach. Instead, this article draws heavily upon qualitative evidence, most notably the archives of the Medical Women's Federation (MWF), including their quarterly newsletter (used to share clinical knowledge acquired in the course of general practice and public-health work) and their Standing Committee on Venereal Diseases (SCVD).[5] These records, which contain detailed information from (and about) numerous women engaged in venereological work, reveal just how closely women's professional identities were bound up with the shifting economics, politics and morality of interwar medicine.

Beginning with the emergence of venereology as a medical specialism in the early 1920s, this article lays out the objectives and organization of the VD Service, which established universal access to reliable diagnostic and therapeutic provisions for diseases that carried great stigma and were traditionally relegated to the periphery of respectable medicine.[6] It then situates women doctors within this new infrastructure, where they capitalized on opportunities to secure much-needed specialist training. Every woman doctor known to have worked in the interwar VD Service was considered for this study. Those who feature were chosen because there was more available biographical data on their clinical activities, salaries, professional relationships and ideological positions on a variety of medico-moral issues. These women

came to the VD Service from a variety of professional backgrounds and at different stages in their careers. But, as this prosopographical study reveals, they shared a number of common, formative professional experiences.

Continually subject to antagonism from male colleagues, they were nonetheless able to assert legitimacy and authority through self-conscious rhetorical and moral maneuvering. They tapped into fears over Britain's moral and physical health, effectively positioning themselves as the rightful guardians of that health. Looking—as Joan Scott has urged us to do—through a poststructuralist lens at language as "a meaning-constituting system" and discourse as a mechanism of power, we can see how these women doctors appropriated the language of masculine medical authority and strategically conflated it with the language of social hygiene and long-standing Victorian assumptions about female modesty, purity and respectability.[7] Their claims to knowledge—embodied within both the institutional framework of the VD Service and their relationships with women patients—constituted uniquely female claims to professional legitimation and authority within a profession that remained inherently masculine.

At its heart, this article challenges historical assumptions about the professional opportunities open to women during the first half of the twentieth century. The VD Service—like obstetrics, gynecology, anesthetics and birth control—was low status, in part because the work was considered to be menial and distasteful. But it was also among the few interwar medical specialisms that offered footholds to women doctors.[8] Studying their professional lives and relationships offers up new perspectives on the provision of care and the gendered politics of sexuality and sexual health in a period of profound economic and social change.

The VD Service

The early twentieth century ushered in a radical approach to the provision of British sexual-health services. This was the product of a long, rancorous debate that had culminated in 1913

with the establishment of a Royal Commission on Venereal Diseases (RCVD).[9] In 1916 the RCVD published its findings, calling for a complete overhaul of civilian diagnostic and therapeutic services. Rolled out thirty years before the National Health Service, the resulting scheme of free, universal care was unparalleled. Importantly, it was part of a pragmatic shift towards socialized healthcare, marking a slow but nonetheless fundamental reconceptualization of the state's role and responsibilities in the care of its citizens.

It also marked an opening up of discussion about the emotional and economic burden of untreated infection—for the individual and the state: "It is impossible yet," lamented the suffragist Agnes Maude Royden in 1917, "to estimate what venereal disease costs us in sickness, lunacy, crime and inefficiency, but the sum must be enormous."[10] Although we have no reliable figures for pre-war infection rates, Simon Szreter has estimated that, on the eve of the First World War, absolute prevalence of syphilis among men aged in their mid-thirties was between 7 and 8.5 per cent.[11] With new diagnostic and therapeutic technologies (such as the Wassermann blood test and arsenical-chemotherapeutic drugs like kharsivan), the clinics helped to correct the shortcomings of pre-war provisions, especially for patients who were unable to afford doctors' fees.[12] The clinics were also intended to be a service to which people could turn voluntarily without fear of notification or stigma. Although historians disagree over the extent to which older forms of medico-moralizing persisted, the RCVD and Ministry of Health were both intent upon a pragmatic health service.[13] Rather than singling out infected persons or attempting to regulate the sexual behavior of a single class or gender, the clinics were designed around a principle of utilitarian non-coercion.[14] Indeed, Britain was among only a handful of countries during the interwar years to introduce an entirely voluntary system of treatment and prevention.[15] These provisions were in stark contrast to the duress, surveillance and notification under DORA and the Contagious Diseases (CD) Acts, which the Commissioners believed had pushed infected persons into the hands of quacks.[16]

Efficiency, convenience, confidentiality and patient compliance were essential.[17] Access to clinics was therefore neither means tested nor restricted according to proximity to a patient's abode. Anyone could access any clinic, having walked in off the street or been referred by a doctor. Clinics were often attached to hospitals and contained cubicles for diagnostic examinations, urethral irrigations to treat gonorrhea and intravenous or intramuscular injections to treat syphilis. On arrival, each patient was issued with a reference number—intended as the only form by which medical staff might identify them. Patients' names were omitted, but their ages, addresses and occupations were usually recorded, as were details of diagnoses, current treatment and whether the patient had previously "defaulted."[18] As time went on, case notes increasingly recorded familial and sexual relationships to track disease transmission and prevalence. The patient registers for St Bartholomew's VD department are a good example. On November 8, 1926, a woman who attended the department was diagnosed with syphilis. On November 12, her husband attended, and, on December 1, she brought their baby for examination.[19] Access to patients' confidential data was restricted to a select few almoners and clerks—a practice that Dorothy Manchée (lady almoner to the VD clinic at St Mary's Hospital, Paddington) believed gave patients a reassuring sense of anonymity.[20]

The first clinics opened in London in 1917. By 1920 there were 190 across the country, with 105,185 patients and nearly 1.5 million total attendances. Numbers continued to increase steadily across the interwar years. By 1938, total attendances were well in excess of three million.[21] Concomitant drops in the prevalence of epidemic diseases resulted in increased expenditure on services for chronic illness and public-health initiatives, including VD.[22] Government funding for the VD Service remained constant throughout the interwar years; even during the Great Depression, it accounted for 3.1 per cent of total health expenditure.[23] Treasury grants met seventy-five per cent of clinic costs, while local rates covered the remainder.[24] In Britain's mixed economy of interwar healthcare, some health authorities opposed these arrangements for condoning vice and constituting an abuse of charity. Among

these voices of opposition was Louisa Martindale (gynecologist, suffragist and one-time president of the MWF), who believed that the entire scheme encouraged vice. She was dismayed to discover that, in 1921 alone, the VD Service cost £224,716 and questioned whether "the thoughtful woman doctor" would not think it "wiser to spend such sums of money in improving the condition of *innocent* necessitous men and women." Sufferers of VD, "by no means always innocently contracted," should contribute to the cost of their own care.[25] But the Chief MOH, Arthur Newsholme, remained adamant that VD could not be combatted in any other way.[26]

The VD Service's success was due in no small part to his advocacy for a comprehensive state medical service. To expedite the implementation of its scheme the LGB bypassed parliament and declared VD a national emergency under the Public Health (Venereal Disease) Regulations of 1916.[27] Under the terms of the 1913 Public Health Act, the LGB could, by declaring a national emergency, compel county councils to cooperate. This obliged local authorities to establish clinics in their areas.[28] As we shall see, women were to play an important role in their establishment and development.

Forging Professional Territory

The first generations of women to enter medicine developed their own career paths and patient constituencies, separate from those of their male colleagues.[29] By the interwar years, however, such gender divisions had begun to break down and women were entering more mainstream practice.[30] Emerging specialisms and growing state intervention helped to create new career paths and the VD Service became an important part of this diversification.[31] Competition for hospital posts was intense and without such coveted appointments, graduates could not acquire the clinical experience necessary to establish successful practices. Even women who

distinguished themselves as medical students struggled to secure hospital appointments or places in general practice.[32]

Women were advised to look beyond obstetrics, gynecology and general practice. Although it would eventually become as competitive as these other fields, the VD Service offered just such an alternative career path.[33] Women came to it from diverse professional backgrounds and in a variety of capacities. Some were appointed full-time. Others were appointed on a part-time basis, using the clinics to acquire much-needed experience while simultaneously establishing general practices or consolidating hospital posts.

In addition to making new diagnostic and therapeutic technologies widely available, the clinics helped to establish venereology as a serious specialism and subject of mainstream study. They eventually became important sites for training young doctors—a corrective to the haphazardness and opportunism of the pre-war period, in which students were taught venereology only if they had a lecturer with particular interest in the subject.[34] Such problems were evidenced in the 1919 course of postgraduate clinical and theoretical instruction organized by the School of Medicine for Women in cooperation with the Female Lock Hospital and the VD clinic at the Elizabeth Garrett Anderson Hospital. It was clear that instructors, such as Oswald Dinnick, the surgeon-in-charge of the Royal Free Hospital's (RFH) male VD department, were assuming that their audiences possessed limited foundational knowledge of VD and were almost completely ignorant of new diagnostic and therapeutic technologies.[35] Fragmented pre-war training meant that, in the clinics' early years, few doctors had sufficient knowledge and skill. Recalling her own experience, Henry lamented that "there were no genitourinary specialists then," so treatment had been left to general surgeons and skin specialists.[36] Many VD MOs had to learn on the job.

By the interwar years, venereology, with its emphasis on hygiene and moral regeneration and its close links with obstetrics and genitourinary medicine, was thought to benefit particularly from the intervention of women doctors.[37] As the MWF regularly reminded its

members, numerous VD appointments were open to women with the desire to acquire the requisite training.[38] Before her move to Blackburn, Henry had gained valuable training as clinical assistant to Rupert Hallam when, in 1916, he had opened the first VD clinic at the Sheffield Royal Infirmary. As she reflected many years later,

> This clinic was the first of its kind […] and Hallam appointed me as the assistant in the women's clinic. I doubt if there is ever seen now the horrible lesions we had to treat. The number of patients increased rapidly and it was at that time intravenous salvarsan was introduced. It added a great deal to our work […] Later on, I did a refresher course in London before taking over the Lancashire post.[39]

The VD Service offered women doctors the clinical experience needed to hone their diagnostic skills. Between 1918 and 1938, Bessie Symington and her staff in Leicester's female clinic examined and treated hundreds of patients each year.[40] The Leicester clinics, like those in every other local authority, had access to laboratory facilities for the analysis of smears, secretions and blood samples.[41] Moreover, to expedite treatment, MOs in larger clinics undertook basic analyses alongside routine clinical examinations, irrigations, douches, injections, lumbar punctures and minor operations.[42] In so doing, they became skilled in the use of delicate, highly specialized apparatus—itself a self-conscious assertion of professional authority.[43] Some clinics, such as Margaret Rorke's at the RFH, also capitalized on large patient numbers by organizing clinical studies. In 1932, Rorke and her assistant MOs investigated different treatment options for vaginal discharge. Concentrating on gonorrhea and discharges during pregnancy, their aim was to find ways of shortening periods of infectivity, as well as lessening the treatment required to achieve a "permanent cure."[44] Doctors like Symington and Rorke were therefore able to observe a wide variety of genitourinary infections and correlate their empirical findings with the results of pathological investigations.[45] By the mid-1920s, the sheer numbers of patients passing through the clinics meant that VD MOs could easily equip themselves with the specialist experience to make prompt, accurate clinical decisions.

But in the early years, clinics in which women doctors could acquire such expertise were scarce. Henry's clinic in Blackburn was one of the few that offered care to women and children. Despite administrative reshuffling during the mid-1920s, when many local authorities transferred the care of married women and their children to the Maternity and Child Welfare Service, there remained considerable structural inequalities in patient provisions and clinical appointments. Women doctors may have been more numerous in the VD Service than most other branches of medicine, but they were still underrepresented. Many hospitals and local authorities, although slowly enlarging and streamlining their male clinics, had not begun even to contemplate similar services for women and children; this was despite repeated calls from the Chief MOH that "women doctors and nurses should be present in all clinics for women and girls."[46] But this was very much an aspiration, not reality. For example, less than fifteen per cent of the almost 6000 patients treated in the Liverpool clinics in 1919 were women. Likewise, in the following year, less than twenty per cent of the clinics' patients were women.[47] Such gender imbalance was not through any lack of demand; rates of infection were not dramatically lower among women and children.

The inability to accommodate more patients certainly played a significant role in such gender disparities. But, as Mary Scharlieb (gynecologist at the RFH) stressed before the 1923 Congress of the Royal Institute of Public Health, MOs were mostly men but "respectable married women prefer to be attended by women medicals."[48] The limited presence and influence of women VD MOs was potentially catastrophic for the health and welfare of patients. When Leicester's MOH capitalized on Symington's retirement in 1938 to establish Hamilton Wilkie as director of the female clinic, Mary Newton-Davis, the assistant MO, was convinced that

> the clinic will be constantly overrun by men doctors, both as visitors and postgraduate classes. Indeed, this has to a small extent been imposed on the female clinic recently, due to his influence […] Under his directorship, the clinic will no

longer be a place where women patients will feel they are safe to be seen only by their own sex.[49]

Similar problems affected the female clinic at the Birmingham General Hospital. In 1923, only five per cent of its patients completed a full course of treatment. This was staggeringly low, especially when compared to clinics in other large industrial cities, where retention rates were around fifty per cent.[50] Birmingham's MOH, John Robertson, concluded that part of the problem were the male clinical assistants and MOs who continued to staff the women's clinics: "a larger number of women would undoubtedly attend if a medical woman were appointed to look after female patients."[51] Although the Hospital's Board were prepared to entertain the possibility that female patients might be less likely to default if their treatment was overseen by women, some members were clearly unconvinced. The Board therefore requested the help of the Birmingham and Midland Hospital for Women (BMHW), which had recently appointed Hilda Shufflebotham in place of a male MO, to disentangle the fraught question of women VD MOs: "The suggestion has often been made that, if a woman were appointed to treat women, we should have fuller attendances at the VD clinics and the information I ask for […] may throw some light in the subject."[52] But, as their evasive and disingenuous reply suggests, the increase in attendances in excess of twenty-five per cent was insufficient for the BMHW to attribute success to a woman's having been given control of the female clinic.[53]

This gender imbalance remained so stark that, in 1929, the MWF publicly urged that "medical officers treating female venereal disease cases, whether in hospitals or clinics, should be women medical practitioners where and whenever such practitioners are available."[54] The British Social Hygiene Council—formerly the National Council for Combatting Venereal Disease (NCCVD)—also resolved that "in areas where two Venereal Diseases Officers are appointed, one should be a woman; […] where such a course is impracticable Medical Officers of Health should take every opportunity of having female Maternity and Child Welfare Officers trained in the diagnosis and treatment of Venereal Diseases."[55] This pressing need for women

doctors marked a radical departure from the pre-war status quo. In her study of case notes from the RFH, Claire Brock found that none of the 1403 gynecological patients seen between 1903 and 1913 reported embarrassment upon being examined intimately by male doctors.[56] Had attitudes changed so dramatically in less than a decade, or was it that female patients, previously resigned to treatment by men, were increasingly able to exercise choice? The scarcity of women doctors in the pre-war period certainly meant that attendance by men was the norm. But as Brock has also found, growing numbers of gynecological patients travelled great distances to be treated at the RFH by Scharlieb and Ethel Vaughan-Sawyer.[57] This pattern was reflected in Martindale's assertion that "once a patient has been treated by a good woman doctor we find she invariably and for the rest of her life continues to choose a woman doctor."[58] Likewise, Frances Ivens (gynecological surgeon at the Liverpool Stanley Hospital and one-time president of the MWF) insisted that women doctors in general practice were increasingly expected to have specialist gynecological skill because so many female patients were "less diffident" about consulting them on matters of sexual health.[59]

The few historians who have studied interwar women VD MOs have focused on the ways that these women asserted their unique suitability for venereological work.[60] Given the longstanding assumptions that women had no business knowing anything about VD, such assertions on the part of women doctors warrant more attention. Even during the interwar years, there was still some queasiness about women (medically trained or otherwise) having intimate knowledge of these unpleasant and stigmatizing diseases. Such queasiness was due to the lingering Victorian belief that knowledge of VD was tantamount to moral and physical corruption, as well as the fear that women with venereological knowledge would be made responsible for the intimate examination and treatment of men.[61] The sidelining in 1920 of a woman doctor for a post as pathologist and bacteriologist is a good example. She had served with the RAMC and was the most senior and experienced of the outgoing pathologist's staff. Nonetheless, the appointment committee were adamant that she could not fill the post because

it might entail collecting specimens from men. The local VD clinic already had a fulltime male MO, but there was not a female MO or pathologist to collect specimens from women.[62] Similarly, in 1923, Birmingham's MOH urged the General Hospital to dispense with the "girl clerks" who recorded patient data in the clinics, arguing that it was not "fair on the girl or likely to be conducive to good work."[63] Again, in 1926, when the General Hospital advertised a clinical assistantship, they rejected an application from Elizabeth Bainbridge, then House Surgeon to Newcastle's Royal Victoria Infirmary, with no explanation other than that the post "must be confined to men applicants."[64]

Despite such opposition, prominent women doctors, including Ivens, Scharlieb and Florence Willey (later Lady Barrett, surgeon to the RFH), had sat on the RCVD and appeared before it as witnesses calling for greater female involvement in the care of infected women and children.[65] Their gravitation into venereology was both rhetorical and practical. During the 1890s the New Woman Movement had crafted shrewd moral and biological arguments for the place of women in professional and public life. Women would be not only a check on male immorality. They were also to become self-styled guardians of female reproductive health.[66] Women doctors capitalized on this gendered rhetoric, arguing that it was their *responsibility* to treat and protect other women. Just as they claimed a vocation as justification for their entry into medicine, so too was the pursuit of specialist venereological training couched in the same religiously infused language.[67] This was a professional calculation.

In her sociological survey of women's medical careers, Mary Ann C. Elston questions whether historians can legitimately assume gender to be the single most defining factor in career development or professional identity.[68] Exploring the gender politics at play in the VD Service offers up a fresh perspective on interwar medical professionalism and work culture. But, despite its skillful deployment, gendered separatism remained just one (albeit important) component of medical women's professional strategy. Scott's poststructuralist critique of the dichotomy between equality and difference provides an apt theoretical framework through

which to understand such strategizing among women doctors.[69] Although female patients appear to have preferred being examined and treated by other women, there is nothing to suggest that they expected male and female doctors to assume dramatically different codes of professional behavior.[70] Women VD MOs appropriated the languages of eugenics and masculine medical authority, skillfully blending them with long-standing Victorian assumptions about female modesty and respectability.[71] In a manner similar to their male colleagues, they crafted a coherent, narrative-driven set of professional credentials. They solidified a collective identity and status, different from that of medical men but intended to be in no way inferior.

VD was bound up with fears over national degeneration, and women doctors tapped into these fears to cement their professional status. By the interwar years, such rhetorical maneuvering (along with heavy campaigning by the MWF and a general relaxation of social and medical sensibilities) meant that women doctors were seen to be better suited to venereological work. Indeed, they constituted twenty-two per cent of interwar VD appointments.[72] This was an extraordinary percentage, given that, by the mid-1930s, women constituted only ten per cent of the Medical Register.[73]

Professional inequalities and antagonism

There were also more pragmatic reasons for welcoming women into the VD Service. Women graduates had limited access to clinical appointments, so they gravitated towards less-prestigious specialisms. Their move into the VD Service also coincided with a wider socio-political backlash against women in an increasingly competitive workforce—a "sex war" in medicine.[74] Shortages of male students during the First World War had prompted many London hospitals to open their doors to women students, some of whom even secured coveted house appointments. By the mid-1920s, however, these gains were mostly lost. As the *British Medical*

Journal (*BMJ*) observed in 1927, there were many informal barriers to women's training and professional practice, at the root of which was "sex prejudice, strengthened by apprehensions of intensified competition."[75] Professional antagonisms were fueled by the perceived undercutting of medical men in a cramped marketplace. Women doctors had their supporters. But many men, especially those returning to medicine from military service, could not abide being taught by women or competing with them for lucrative appointments.[76]

Many men objected to working alongside female colleagues on terms of professional equality. The experiences of Symington and Newton-Davis are illustrative of these tensions. Symington had been appointed in 1916 to run the women's clinic on the understanding that she would have complete control, which she maintained for twenty-one years. But when Wilkie was appointed in 1932 to take charge of the male clinic, he began styling himself as the head of both clinics. According to Newton-Davis, Wilkie quickly became a "favorite of the Chairman of the local VD Committee who [was] antagonistic to women and determined to advance the material and professional position of Dr Wilkie at any cost."[77]

Not all inequality in the VD Service was accompanied by such open hostility. Henry was the first woman doctor that any of her patients and most of her colleagues in Blackburn had ever seen, but she claimed that they were all "very cooperative." Such an assertion sits awkwardly with the antagonism generally directed towards women at the time.[78] Henry's warm reception probably had more to do with her assuming responsibility for a collection of distasteful cases. In so doing, she had removed herself from competition for other medical appointments and allowed her male colleagues to get on with more remunerative and prestigious work.

Despite the Ministry of Health's efforts to establish the respectability of venereology, it remained marginal to the interests of most doctors and lacked the prestige of other fields like physiology or general surgery. Clinics were often allocated the worst hospital and municipal facilities and VD MOs were derided as "pox doctors." Moreover, the VD Service could not

offer the same opportunities for career advancement as other specialisms.[79] Women doctors, who already existed on medicine's professional periphery, were therefore a convenient fit. Following her appointment, Henry was dismayed to find that she had been given a tiny, gloomy and unventilated office in the basement of Blackburn's Town Hall, which she had to share with the local school nurses.[80] She may have been welcomed by her colleagues, but that did not mean she was entitled to the same resources or opportunities for professional advancement.

In 1917 the MWF asked members working in the VD Service whether they believed themselves to be treated fairly in appointments and promotions. The answers were ambivalent. Opportunities for promotion were slim. The British Medical Association and Society of Medical Officers of Health, in conjunction with the Ministry of Health, had mandated that no sex-distinction be made regarding payment or appointment.[81] Yet women were often sidelined. In contravention of the Sex Disqualification (Removal) Act, some local authorities refused to appoint women doctors. Other local authorities attempted to "inveigle women medical practitioners into the cul-de-sac appointments by offering an annual salary of £600 (or less) per annum just after qualification."[82] For example, when Edinburgh advertised for a Clinical Assistant Medical Officer at an annual salary of £750 and a Junior Medical Assistant at an annual salary of £400, it added that "a Lady Medical" might be appointed to the junior post—the implication being that female applicants would not be considered for the better-paid, senior appointment.[83] These problems were so pervasive that, throughout the 1920s, the MWF urged its members not to accept annual salaries of less than £600 or sessional fees of less than one-and-a-half guineas for work in clinics.[84] It placed advertisements in the *BMJ* and the *Lancet* urging women doctors to check with the MWF before accepting appointments in the VD Service. Any woman found to be applying for an underpaid post was sent a personal letter admonishing her to

> do nothing to help the authorities in what, unfortunately, appears to be their policy with regard to these clinics, namely, to make the medical women in charge of the

> female side permanently junior to the men and with smaller salaries […] In cases where the medical woman is already experienced in VD work, the Federation would strongly urge her, in the interests of all medical women, not to accept the post without first pressing for equal pay, equal status and full control over the female clinic.[85]

By 1925, ninety-six women had received these letters.[86] Ivens, then president of the MWF, was scathing both of the local authorities who advertised such posts and the women who accepted them.

> It is humiliating to know that last year out of thirteen applicants for underpaid posts who accepted them in spite of protest, eleven were women. Such a selfish attitude cannot be too sharply deprecated. It is calculated to lower the prestige of medical women in the eyes of their colleagues and of the public.[87]

But these were the pronouncements of women in positions of professional privilege, who were not required to compete for scarce clinical appointments. As we can see from the administrative records of the RFH's VD department, salaries as large as the MWF demanded were very unusual even among senior MOs. In June 1924, Rorke petitioned the RFH and the London County Council (LCC) to fund a significant expansion of the clinic's facilities, as well as salary increases for its staff. Her salary was increased from £400 to £500, while the senior assistant's annual salary was more than doubled from £200 to £500. By 1927, Rorke was earning £750 per annum, but this was reduced by £200 to accommodate new staffing demands.[88] Even the RFH, which ran one of the largest female clinics in the country, was paying its staff well below the minimum demanded by the MWF.

Salary thresholds were still a source of antagonism in 1927 when the MWF laid down a series of principles that included the following: "a woman who has betrayed her professional brethren past, present and to come, cannot expect the support of her colleagues or of professional organisations at any time in her career [...] The woman who stamps herself as belonging to an inferior grade of doctor cannot complain if she is taken at her own valuation."[89]

Concerned that such undercutting would alienate women doctors and undermine the push towards professional equality, the MWF sought to protect collective interest and status by threatening to name, shame and ostracize any woman who applied for an underpaid post.[90]

Despite such problems, the VD Service provided entrée to important public-health organisations, such as the NCCVD and Royal Institute of Public Health, through which women could cultivate professional networks. It also enabled women, drawing on their work in the clinics, to publish in prestigious journals.[91] Women VD MOs were also able to shape policy through participation in government inquiries. Appointed in 1922 to Lord Dawson's committee, Morna Rawlins (Assistant VD MO at Guy's Hospital) collaborated with the SCVD to acquire information on various forms of prophylaxis.[92] Likewise, Martindale, Barrett and Erie Evans (VD MO in Cardiff) were selected in 1923 as the MWF's representatives to Lord Trevethin's Standing Committee.[93]

But although the VD Service offered women more professional opportunities than were available in most other fields of medicine, they did not, as a rule, have autonomy. Henry's post in Blackburn, which was comparable to a large practice in a busy industrial city, was unusual. Allocated beds at the Lancashire Hospital and assigned a nurse, who she trained to assist her in the VD clinic, Henry felt that she had been given "a free hand" to make it successful. Like the MOs at the RFH, Henry had an unusual degree of control over her clinic. Women may have encountered less resistance in the VD Service, but venereology was by no means uncontested territory. Rarely did they have complete charge of the patients under their care.[94] For example, the Board of the Leeds General Infirmary appointed a woman doctor in 1923 to assist in the women's clinics. But unlike Henry and Rawlins, she only assisted the superintending MO. If there was insufficient venereological work to keep her busy, she did not enjoy the same opportunities as her male colleagues, who were offered posts as House Physicians in the Infirmary's Skin Department.[95]

The Sympathetic Medical Officer

Historians are increasingly eschewing staid interpretations of doctor–patient dynamics in which patient subordination and medical authority are defined primarily by gender—patriarchal doctors admonishing and controlling female patients.[96] Male and female doctors alike were swayed by ideology, prejudice and professional ambition.[97] They distinguished transgressive patients—a loosely defined group that included defaulting men, "good-time" girls, merchant seamen and prostitutes—from those they identified as victims.[98] Married women and their children were, on the whole, classed as victims of philandering husbands. Although the "willful communication" of VD had been grounds for divorce for many decades, the majority of afflicted women remained bound to their husbands.[99] As the MWF observed, "a married woman could hardly take precautions against her own husband nor has she any real protection against disease that may be acquired from her husband."[100] Their treatment was therefore tailored accordingly. By the mid-1920s, increasing numbers of women doctors began publicly to advocate for these patients to be transferred to the Maternity and Child Welfare Service. For doctors like Janet Campbell (senior MO at the Ministry of Health for maternity and child welfare and, later, president of the MWF) and Mable Brodie (senior welfare MO to the Durham County Council), it was a question of practicality as much as morality.[101] The married women who attended Brodie's clinic objected to being treated alongside prostitutes and she feared that they might default.[102] Scharlieb shared these fears, believing that many women failed to avail themselves of treatment because they did not care for "the companionship of some of the patients met with at these clinics."[103] Likewise, in 1918, the RFH had deemed it 'very undesirable' that children attending adult clinics had to "sit and hear the conversations of the younger women," whose bad characters might have a detrimental influence.[104] The transfer of responsibility by local authorities to the Maternity and Child

Welfare Service was hoped to reduce rates of congenital infection, but it also served to segregate patients on moral grounds.

Yet even transfer to the Maternity and Child Welfare Service was problematic. Having dual responsibility in Blackburn for women's sexual and reproductive health, Henry could oversee a holistic program of care for mothers and babies, thereby building cooperation and trust. It convinced her that "a mother acquires confidence in one doctor and is unwilling to make further confidences if transferred to a new one, and the fact that the same medical woman is personally interested in her little family goes a long way to gaining consent to treatment."[105] Unfortunately, this type of care was not the norm. At the Queen Charlotte's Hospital antenatal clinic, any women who presented with a vaginal discharge was referred to the VD clinic at the RFH. Many patients resented this protocol and would attend for treatment only during their pregnancies.[106] Likewise, at the Leicester Royal Infirmary, only a handful of women referred from the antenatal clinics actually attended the VD clinic. Symington believed that the majority were deterred by the "publicity" of the waiting room.[107] In the 1930s, the SCVD was still reporting that large numbers of infected women and children were failing to be "drawn into the scheme" or defaulting with an untreated infection and a new-born at risk from congenital syphilis or ophthalmia neonatorum.[108]

Although "innocent" defaulters were dealt with more sympathetically, they were nonetheless subjected to subtle (and not-so-subtle) systems of surveillance. However understandable their motives for discontinuing treatment, defaulting was nonetheless criticized as reckless. Action was therefore needed to bring these patients back to the clinics. Clinics regularly reviewed their patient lists and sent "non-committal letters" to those who missed their appointments. Manchée found that few women gave false names or addresses, making them easy to trace. Writing in 1938 about these follow-ups, she described a system in which the boundary between medicine and morality was frequently blurred. As the VD Service was removed from the direct-payment schemes that became integral to Britain's mixed economy

of interwar healthcare, its almoners were not required to assess patients' ability to pay for treatment.[109] Rather, they, along with the Service's nurses and MOs, became part of a complex surveillance infrastructure.[110] If a woman defaulted, she would receive a generic printed circular, requesting that she attend the clinic as soon as possible. These circulars included no identifying information about the clinic or the reason for her requested attendance. If this first communication went unanswered, a second, personalized letter was sent, offering to discuss her reasons for non-attendance. It also warned that a health visitor would call if no response was forthcoming.

These measures were never legislated. The Ministry of Health was not sent patients' particulars. Neither were most women compelled to persist with their treatment. Nonetheless, such coercion and surveillance was troublingly reminiscent of the CD Acts. Despite government mandates that the VD Service not be used to target specific groups or compromise patient confidentiality, it allowed health professionals to exert influence over their patients' private lives. Brodie went so far as to call explicitly for greater "supervision" of infected homes.[111] Through follow-up letters, health visits, infection monitoring and programs of sexual-health education, the clinics became central to a wider strategy of social and moral control. According to Letitia Fairfield (a NCCVD policymaker and the LCC's first female senior MO), it was "futile" to try to curtail the spread of infection without a much-enlarged network of VD almoners to perform this type of "social work." Speaking in 1939 before the Social Hygiene Congress, she lamented that there were still only three full-time and twelve part-time VD almoners, only one of which worked outside London. Although Fairfield called for the appointment of male almoners to keep track of the young men attending clinics, what little social work was conducted within the VD Service focused primarily on the surveillance of women—quite possibly the result both of long-standing assumptions about the role of women as vectors of contagion and the belief that they were more tractable.[112] Manchée insisted that this was nothing more than friendly and sympathetic support for distressed,

unmarried mothers and harassed housewives. But the "helpful" reminders and follow-up visits to family homes suggest that subtle coercion was also a key part of the modus operandi, at least where working-class and lower-middle-class patients were concerned. These patients were viewed as particularly unreliable, so health professionals took steps to monitor and moralize their sexual behavior and hygiene practices.[113]

VD threatened to compromise the nation's moral and physical health and, through congenital syphilis and gonorrheal ophthalmia neonatorum, the health of future generations. The development of new diagnostic technologies meant that doctors were increasingly aware of the ineffectiveness of older, pre-war therapies. New etiological, morphological and pathogenic knowledge meant that, by the interwar years, health authorities recognized the necessity of more standardized treatment regimens. Moreover, the development of new drugs like salvarsan substitutes and sulphonamides imbued the treatment of VD with newfound optimism. Indeed, health authorities were increasingly convinced that therapeutic interventions were not only necessary but now also far more likely to be effective. With this new optimism on the one hand and lingering fears over national degeneration on the other, the punitive aspects of reminder letters and follow-up visits assumed a new light. Given especially the implications of infection for national fitness and reproductive health, women VD MOs believed that they had a duty of care not only to their patients, but also to the wider community. Like the VD Service itself, the ethical decisions of these women were underpinned by a utilitarian commitment to the welfare of the individual *and* community. And as we shall see, these competing commitments were often fraught with tension.

Women doctors may have moralized, but they were also sensitive to the fact that clinical encounters were rarely textbook. Patients obfuscated and were confused. Treatments did not always go to plan.[114] Nowhere was this more evident than in the VD Service. Gladys Sandes, writing for the *Clinical Journal* in 1933, stressed the necessity of "psychological treatment" alongside clinical care.

> The patient frequently comes in a state of profound anxiety. The intelligent patient especially is imbued with a sense of 'uncleanness,' and our first efforts should be directed towards changing her outlook. Vague phrases are not sufficient to ally her fears; she should be treated as a responsible person, and her cooperation invited […] I invariably inform the patient of her exact condition as soon as the diagnosis has been established, giving her at the same time a reassurance as to ultimate cure if she carried out her treatment conscientiously. The normal person is most afraid of the unknown, and if the position is put before her carefully, avoiding crudity so far as is possible, I have never found her to fail to respond [….] I do feel strongly that 'honesty is the best policy' and deplore the practice of certain clinics where the patients attend for long periods without any real understanding of the disease from which they are suffering.[115]

Medical women brought more to the clinics than their knowledge and skill. Brock and Anne Digby believe that they were also more willing than men to push past simple symptomatic approaches and instead consider their patients' illnesses within a wider social context.[116] As doctors, nurses and almoners they certainly developed an important understanding of the *social* practicalities of disease management. This was particularly apparent when, in 1920, the MWF challenged advice issued by the Society for the Prevention of Venereal Disease (SPVD)—advice that, it later transpired, was intended only for prostitutes.[117] The MWF was scathing, believing the SPVD's instructions for the internal application of prophylactic ointments to be impractical for most women.

> In most cases infection occurs through the cervix and it is very difficult for the average women to reach this for thorough disinfection […] To offer such advice to people who are poor, and who have no privacy nor necessary utensils nor real ideas of personal cleanliness, would be to mock them.[118]

Such emphasis on the ethics and practicalities of care was a deliberate attempt on the part of medical women to position themselves as experts. We can see this clearly in Manchée's manual, in which she insisted that there were important gendered and economic factors behind decisions to forgo treatment—factors that had not been given adequate consideration by male medical authorities. Respectable women who defaulted were thought to be compelled by feelings of shame and despair; fearful that someone might discover that they were frequenting a VD clinic. They might be ignorant of the severity of their illness, or so constrained by domestic responsibilities that they convinced themselves that treatment was of secondary importance to housework and childrearing. But they might also be justifiably concerned about the side-effects of treatment or fall victim to deficient sexual-health education and administrative bungling within the clinics.[119]

The numbers of patients seeking treatment were constantly rising, but so were the numbers of patients defaulting. As early as 1920, it was apparent that clinics were struggling to stop patients slipping through the cracks.[120] Treatment regimens, such as those employed at the Leicester Royal Infirmary and the RFH, were long, painful and distressing. It is therefore unsurprising that many patients stopped returning once their symptoms disappeared but before a complete "cure" had been achieved. Although writing specifically about the treatment of patents in Leicester's male clinic, Henry Blakesley's 1921 article in the *BMJ* gives a good indication of the lengthiness and trauma involved. Patients with syphilis were subjected to many months of painful intravenous injections of kharsivan, intramuscular injections of mercury and multiple courses of *Hydrargyrum cum Creta* (mercury pills). All this was interspersed with diagnostic Wassermann tests, positive results on any of which would necessitate restarting treatment. The entire monotonous and distressing process would last longer than eight months.[121] But this was short compared to the three-year regime employed in 1918 by the female VD clinic at the RFH. When the Medical Committee discussed the knotty question of a "standard of 'cure'," they concluded that syphilitic patients should, throughout

their first year of treatment have Wassermann tests at least every three months. During their second year of treatment, Wassermann tests needed to be performed at least twice. If the Wassermann tests remained negative for an entire year following the cessation of treatment, the MO would cautiously pronounce the patient cured.[122] Defaulting was so common that Rorke, exasperated by the many "recalcitrants" who discontinued treatment "long before they were non-infective," called publicly for notification and compulsion.[123]

High rates of defaulting also suggest that patients' understanding of their health differed from the clinical metrics used by doctors. Patients were not consulted about their treatment. They may have baulked at treatments that did not conform with their expectations or feelings about their own wellbeing, but in the clinical pursuance of cure, most patients had little input.[124] Aside from the important social factors that influenced a person's decision to discontinue treatment, some patients probably saw the disappearance of symptoms as equal to cure, regardless of the assertions and entreaties by medical or nursing staff. Certainly, in cases of untreated syphilis and gonorrhea a woman's symptoms would lessen and the "ignorant sufferer"—as Manchée described her—would believe that she was either getting better without treatment or had not been sick in the first place. There was also a degree of self-deception in this. Although concerted sexual-health campaigns had increased public awareness of the dangers of VD by the Second World War, older moral paradigms continued to deter women from seeking care.[125] They were all too willing to convince themselves that discharges, rashes, abdominal tenderness and micturition were trivial, isolated complaints. Lacking coherent sexual-health education, they might wrongly regard these complaints as inevitable, dismissing their symptoms (if they were indeed symptomatic) as "an attack of the whites."[126] To think otherwise was to contemplate the possibility that they had contracted a sinful disease.

The distress accompanying a positive diagnosis meant that clinic staff often needed to assume the role of confidant, liaising with patients, supporting those who struggled with treatment and encouraging and cajoling where necessary. As Henry insisted, for patients to

willingly seek treatment, it was essential that clinic staff appear sympathetic and personally interested in each case.[127] Propaganda was an essential tool in this process. Health films especially helped to normalize the clinics as the go-to service and make relatable the women who staffed them. Henry, like many interwar MOs, was given the use of local cinemas and loaned by the NCCVD collections of films that proved exceptionally popular. She was gratified to find that screenings often attracted audiences in excess of a thousand young persons and attributed such turn-outs to the increased numbers of patients attending her clinics.[128] Such propaganda manufactured an idealized image of the woman VD MO as a stoic and rational, yet sympathetic, friend to the troubled woman.[129] But the reality was usually much more complicated.

The Moralizing Medical Officer

Debate over the management of defaulting patients often descended into simplistic dichotomies of innocence and guilt, virtue and immorality, responsibility and irresponsibility. The sympathy enjoyed by married women and their children rarely extended to unmarried or promiscuous women, who were treated with varying degrees of "paternalism," condescension and indignation. Women doctors might have been more candid with their patients, but this did not mean that they were less moralizing. Unlike married patients, worn down by domestic duties and deterred by the fear of stigma, "troublesome" or "goodtime" girls supposedly defaulted because they were willful. Samantha Caslin has shown that, despite the Ministry of Health's efforts to neutralize the stigma and prudery surrounding infection, the language of guilt and irresponsibility continued to shape care at a local level, especially where working-class women were concerned.[130] We see this clearly in the attitude of Louise McIlroy (an obstetrician and gynecologist at the RFH). She insisted that, when treating VD patients in the maternity department, unmarried women, "no doubt some of […] the prostitute class," should remain

isolated from "decent married women."[131] Six years later, several young women discharged themselves prematurely from a hostel attached to the RFH. They were written off as impatient "run-aways" who, attracted to the outside world by "some man," wantonly disregarded medical advice.[132] Of the single woman engaged in casual sex, the MWF was equally unequivocal.

> The damage to a woman whose whole reproductive cycle is violently checked and whose energies are used for the single purpose of sexual congress is very great. Deterioration of character is a usual result of such a one-sided and irresponsible life. In addition, the cultivation of the sex impulse to the exclusion of all modifying factors and safeguards leads to […] selfish want of consideration for others and to over-sexing and perversion.[133]

These women had, in the opinion of the SCVD, forsaken their natural roles as arbiters of morality and protectors of racial health. For Henry, whose work was couched in the rhetoric of social purity, treatment was futile without also addressing such moral shortcomings.[134] But what these moral interventions should entail remained a matter of debate. There were, for example, frequent calls for unmarried women to be institutionalized and subjected to compulsory treatment. Although such punitive measures were never reinstated on the same scale as under the CD Acts, at-risk or problematic groups, including unmarried mothers and the feeble-minded, remained subject to various forms of compulsion.[135] Institutions like the hostels attached to the RFH were set aside for unmarried women receiving treatment in nearby clinics. For their moral and physical health, they were kept under medical observation until deemed free from infection and, in Henry's words, "ready to make a fresh start in life."[136] The objective was to treat and isolate. The "inmates," as they were called, were kept for upwards of eight weeks, "for by segregating and treating infectious persons, the community is protected."[137] In some local-authority areas, women were forbidden to leave "without a satisfactory arrangement for her future housing being received by the medical officer."[138]

In the absence of coercion, other mechanisms were found. As their 1919 resolution demonstrates, the MWF were convinced that effective treatment and prevention necessitated complete trust and compliance, which could be secured only if patients' confidentiality and autonomy were respected.

> The most important factor in the cure of the disease is early treatment, and any method of dealing with the disease which is likely to lead those infected to conceal their condition and to delay treatment will be a most dangerous expedient and may easily lead to a serious increase of the disease. […] we believe that no method has any chance of success which neglects either or both of these factors. [139]

They reiterated this position in 1928 when the municipal authorities in Edinburgh attempted to introduce compulsory notification and treatment. In their statement of opposition, the MWF maintained that such measures would "tend to discourage early cases, who are usually most curable and most infectious […] It bases this conviction on the invariable result of such compulsory powers where they have been applied."[140]

But there was serious concern about what, in the absence of compulsory notification and treatment, would be the most successful and ethical approach. On the one hand, members of the SCVD insisted that clinic attendance was growing because "the people have absolute confidence that their names and identities are not disclosed."[141] Any contemplated return to compulsory notification and treatment would undermine this confidence. In her 1917 NCCVD-commissioned pamphlet, Royden described the terrible situation thus.

> The idea that to suffer from venereal diseases is to be a moral outcast is so deeply rooted, that even now a man who suspects himself of this malady is only too likely to go to a quack rather than to a properly qualified doctor. If he knew that the doctor would be bound to notify the nature of his disease, even though the notification was supposed to be secret, he would be still more likely to fight shy of the doctor. And

> this is at least as true for women, in whom an offence against morals is held to be more criminal than in a man.[142]

This was the crux of the problem. The MWF trod a fine line. They shared the NCCVD and SPVD's pragmatic belief that such measures would simply push infected persons towards quacks or forgoing treatment entirely. All three societies espoused chastity as the only absolute preventive, debunking long-held beliefs that it was injurious to men's health. They were also alarmed by the perceived spike in infection among "'amateurs' of all classes, even in young women of the class who were hitherto so sheltered as to be immune."[143] But their responses differed markedly. The MWF and NCCVD would not countenance medical prophylaxis. Like the MWF and NCCVD, the SPVD condemned extra-marital intercourse. Unlike the NCCVD, however, it conceded that such behavior was increasingly common and that programs of prevention needed to reflect this. Although the SPVD supported the clinics, they believed that reactive treatment alone was insufficient.[144] In advocating medical prophylaxis, the SPVD distinguished between promoting self-disinfection and promoting vice: "teaching people what to do when they have run into danger is not the same thing as telling them you approve of their running into it."[145] For the MWF and NCCVD, the distinction was not so straightforward.

Women VD MOs did not hold a single, straightforward position in the seemingly polarizing debates over the virtues and vices of different preventative practices.[146] In addition to their clinical work, they were expected to impart verbal and written advice about forms of moral, but not medical, prophylaxis.[147] The SCVD, which had been established in 1918 in response to prophylactic "propaganda," derided the SPVD's advice as "morally dangerous and medically unsound."[148] In criticizing the SPVD's prophylactic advice, the SCVD drew heavily on the language of eugenics. In previous decades, degeneration had been bound up primarily with having and transmitting infection. But by the interwar years, the possibility of treatment and prevention at the expense of moral purity was also increasingly criticized as a source of degeneration.[149] Also troubling for the MWF was the possibility that ablution and prophylaxis

would, when used by women, become a contraceptive.[150] As Lesley Hall and Caroline Rusterholtz have shown, although individual members of the MWF were increasingly receptive to birth control and the dissemination of contraceptive knowledge, the organization itself remained ambivalent throughout the interwar years.[151] The MWF insisted that "if married women as well as single were to use prophylactics to protect themselves against venereal disease, and the methods were successful, it is clear that the race would tend to be wiped out."[152]

Although opposed to notification and regulation, the MWF condemned any measure that might facilitate promiscuity. One such measure was the SPVD's proposed ablution centers, to which people might come for disinfection after exposing themselves to risk through illicit intercourse. Reporting in 1919 on the SPVD's proposal, the MWF did not mince its words. They feared that the public would mistakenly believe that casual sex had been made safe and countenanced by the state, thereby leading to "decadence of the race."

> Whether or no [sic] safety could be obtained, promiscuous intercourse would be looked upon as free from risk of infection and to a great extent free from risk of conception and as recognized and protected but the State and Health Authorities, who would become in the eyes of the ignorant the consenting party to their actions. We believe that by no such method can the problem of venereal disease be met and that a phase of society would be produced as vicious and degenerate as any of which history has recorded. Safety from infection would not be attained, while moral degeneration and sex excesses would rot the very foundation of society.[153]

Working on the assumption that promiscuous indulgence would never be safe, the SCVD expressed serious concern that any form of medical prophylaxis "would inevitably lead to increased indulgence and quite possibly to increased disease."[154] Despite the private views of its members (and growing socio-medical awareness that publicity and shame would drive infected persons into the hands of quacks), the MWF, at least in the early interwar years,

continued to view the specter of infection as a useful deterrent to illicit intercourse. Despite concerted public-health efforts to distance VD from long-standing associations with sinfulness, the MWF continued to give equal weight to the epidemiological *and* moral dangers of infection. Its official position centered around a moral discourse heavily infused with eugenic anxieties about racial health and national efficiency.

Conclusions

The interwar years were a period of intense professional consolidation for medical women, and the VD Service was a strategic battleground. Venereology may have started life as a marginal and distasteful specialism, but it gave women space to cultivate professional authority and status. It soon became as competitive a career path as the fields to which it had initially been recommended as an alternative. The eventual legitimization of venereology also did much to improve the experiences of women who *sought* treatment. Writing in 1945, Martindale was pleased to note that syphilis-infection rates had fallen consistently throughout the 1920s and 1930s.[155] But the terms on which treatment was offered were uncompromising; the VD Service might have been founded on principals of free, universal healthcare, but subtle forms of coercion and surveillance bubbled under the surface. As we have seen, these tensions often spilled over in debates within the MWF as well as in its interactions with other societies.

Despite attempts to move away from the regulatory mechanisms that defined nineteenth-century responses to VD, women doctors remained embedded within a framework that prioritized stigma, shame and compulsion as essential preventives.[156] In 1935, Dr Violet Russell (antenatal MO for Kensington) was complaining that, despite the ample treatment facilities available, stigma remained a serious impediment: "in part perhaps natural, but principally due to the ignorance both of the public and the old-fashioned medical practitioner and nurse."[157] Historians have speculated that such moralizing by women was part of a wider attempt to

assimilate into the medical fraternity. Women doctors shouldered an intersectional identity, defining themselves according to feminine norms and masculine codes of professional conduct. Reaffirming moral and social values brought them into alignment with their male colleagues and the wider public, thereby helping them to establish a form of social and professional capital.[158]

[1] University of Sheffield Special Collections, Records of Lydia Henry: VD Medical Officer, Blackburn Lancashire, Audio Recording MS110/1/3A. (Henceforth Records of Lydia Henry, MS110/1/3A.)

[2] See, for example, Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850–1995* (Massachusetts, 1999); Mary R. Walsh, *'Doctors Wanted, No Women Need Apply:' Sexual Barriers in the Medical Profession, 1835–1975* (New Haven, 1977); Regina Markell Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (Oxford 1985).

[3] Laura Kelly, *Irish Women in Medicine, c.1880s–1920s: Origins, Education and Careers* (Manchester, 2013); Carol Dyhouse, 'Driving Ambitions: Women in Pursuit of a Medical Education, 1890–1939,' *Women's History Review* (1998): 321–43.

[4] For more discussion of the methodology of prosopography, see C. Wetherell, 'Historical Social Network Analysis,' M. van der Linden and L. J. Griffin (eds), *New Methods for Social History* (Cambridge, 1999), 125–44; K.S.B. Keats-Rohan (ed.), *Prosopography Approaches and Applications: A Handbook* (Oxford, 2007); Lawrence Stone, 'Prosopography,' *Daedalus* (1971): 46–79.

[5] Established in 1916, the MWF (itself woefully understudied) played an important role in promoting the interests of medical women and shaping their professional identities. Throughout the interwar years, it exercised considerable medical and political influence over a variety of issues, including maternal and infant welfare, birth control, prostitution and VD. For discussion of the history and activities of the MWF, see Lesley A. Hall, 'Eighty Years of the Medical Women's Federation,' *Bulletin of the Medical Women's Federation* (1997): 6–9; Kaarin Michaelsen, '"Union is Strength:' The Medical Women's Federation and the Politics of Professionalism, 1917–1930', Krista Cowman and Louise A. Jackson (eds), *Women and Work Culture: Britain, 1850–1950* (London, 2017), 161–76.

[6] Caroline Rusterholz has observed similar patterns of professional marginalization and opportunity among women who worked in birth control. See Caroline Rusterholz, 'English and French Women Doctors in International Debates on Birth Control, 1920–1935," *Social History of Medicine* (2017): 328–47.

[7] Joan W. Scott, "Deconstructing Equality-versus-Difference: Or, the Uses of Poststructuralist Theory for Feminism," *Feminist Studies* (1988), 34–35; Joan W. Scott, "Gender: A Useful Category of Historical Analysis," *The American Historical Review* (1986): 1053–75; Michel Foucault, *The Archaeology of Knowledge* (New York, 2002).

[8] For discussion of women's clinical work in these fields, see Claire Brock, *British Women Surgeons and their Patients, 1860–1918* (Cambridge, 2017); Lesley A. Hall, "A Suitable Job for a Woman: Women Doctors and Birth Control to the Inception of the NHS," Anne Hardy and Lawrence Conrad (eds), *Women and Modern Medicine* (New York, 2001), 127–47; Anne Digby, *The Evolution of British General Practice, 1850–1948* (Oxford, 1999), 154–86; Lynsey T. Cullen, "Patient Records of the Royal Free Hospital, 1902–12" (Unpublished PhD Thesis, Oxford Brookes University, 2011).

[9] For discussion of the RCVD and the testimony presented before it, see Anne R. Hanley, *Medicine, Knowledge and Venereal Diseases in England, 1886–1916* (London, 2017).

[10] Agnes Maude Royden, *The Duty of Knowledge: A Consideration of the Report of the Royal Commission on Venereal Diseases, especially for the use of Social Workers* (National Council for Combatting Venereal Diseases, 1917), 6.

[11] Simon Szreter, "The Prevalence of Syphilis in England and Wales on the Eve of the Great War: Revisiting the Estimates of the Royal Commission on Venereal Diseases 1913–1916," *Social History of Medicine* (2014): 508–29.

[12] For discussion of pre-war treatment facilities, see Local Government Board Report on Venereal Diseases, PP 1913 XXXII, Cd 7029; Hanley, *Medicine, Knowledge and Venereal Diseases*, 147–73.

[13] Samantha Caslin, "Transience, Class and Gender in Interwar Sexual Health Policy: The Case of the Liverpool VD Scheme," *Social History of Medicine* (Advance Access September 2017), 1–21; Susan Lemar, "The Liberty to Spread Disaster:" Campaigning for Compulsion in the Control of Venereal Diseases in Edinburgh in the 1920s," *Social History of Medicine* (2006): 73–86; Francesca Moore, "A Mistaken Policy of Secretiveness:" Venereal Disease and Changing Heterosexual Morality in Lancashire, 1920–35," *Historical Geography* (2015): 1–19.

[14] Prevention and Treatment of Venereal Diseases. Recommendations of the Royal Commission; Action Taken by the Local Government Board; Progress Made with Schemes of Treatment; and Particulars of Certain Schemes, PP 1917–18 Cd 8509.

[15] For examples of interwar European VD legislation, see Lutz D.H. Sauerteig, ""The Fatherland is in Danger, Save the Fatherland!" Venereal disease, sexuality and gender in Imperial Weimar Germany," Lesley A. Hall and Roger Davidson (eds), *Sex, Sin and Suffering: Venereal Disease and European Society Since 1870* (Abingdon, 2001), 76–92; Ida Blom, *Medicine, Morality and Political Culture: Legislation on Venereal Disease in Five Northern European Countries, c.1870–1995* (Lund, 2012); Susannah Riordan, "Venereal Disease in the Irish Free State: The Politics of Public Health," *Irish Historical Studies* (2007): 345–64; Virginie De Luca Barrusse and Catriona Dutreuilh, "Pro-Natalism and Hygienism in France, 1900–1940: The Example of the Fight against Venereal Disease," *Population* (2009): 477–506.

[16] For discussion of the CD Acts, including their promulgation, remit and controversy, see Judith Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (Cambridge, 1983). DORA 13a was passed in 1915 and prohibited women convicted of soliciting from being in the vicinity of military camps. In 1918 DORA 40d made it illegal for infected women to have intercourse with servicemen. These measures were repealed after the war. See Laura Lammasniemi, "Regulation 40D: Punishing Promiscuity on the Home Front during the First World War," *Women's*

History Review (2017): 584–96; Lucy Bland, "'Guardians of the Race', or "Vampires Upon the Nation's Health"? Female Sexuality and its Regulation in Early Twentieth-Century Britain," Elizabeth Whitelegg (ed.), *The Changing Experience of Women* (Oxford, 1982), 383–86.

[17] Roger Davidson, *Dangerous Liaisons: A Social History of Venereal Disease in Twentieth-Century Scotland* (Amsterdam, 2000), 55.

[18] Dorothy Manchée, *Social Service in the Clinic for Venereal Diseases* (London, 1938); Davidson, *Dangerous Liaisons*, 55.

[19] St Bartholomew's Hospital Archives and Museum, Special Treatment Centre Patient Registers (male and female), 1917–1931, SBHB/MR/31/1.

[20] Manchée, *Social Service in the Clinic for Venereal Diseases*, 18.

[21] Anon., "The Venereal Disease Scheme in England and Wales in 1938," *BJVD* (January 1940), 75.

[22] Alysa Levene et al., "Patterns of Municipal Health Expenditure in Interwar England and Wales," *Bulletin of the History of Medicine* (2004), 653.

[23] Levene et al., "Patterns of Municipal Health Expenditure in Interwar England and Wales," 648, 651.

[24] Royal Commission on Venereal Diseases, PP 1913–16 Cd 8189 (Final Report), 48.

[25] Louisa Martindale, *The Woman Doctor and Her Future* (London, 1922), 150. Emphasis added.

[26] John M. Eyler, *Sir John Arthur Newsholme and State Medicine, 1885–1935* (Cambridge, 1997), 277–94.

[27] For discussion of the difficulties accompanying the creation of the VD Service, see David Evans, "Tackling the "Hideous Scourge:" The Creation of the Venereal Disease Treatment Centers in Early Twentieth-Century Britain," *Social History of Medicine* (1992): 413–33.

[28] Prevention and Treatment of Venereal Diseases. Cd 8509, 2; Evans, "'Tackling the "Hideous Scourge'," 421.

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[31] Mary Ann C. Elston, "Women Doctors in the British Health Services: A Sociological Study of Their Careers and Opportunities" (Unpublished PhD Thesis, University of Leeds, 1986), 9.

[32] Dyhouse, "Driving Ambitions," 337. See also Anon., "Women in Medicine," *BMJ* (September 1, 1923), 383.

[33] See, for example, London Metropolitan Archives, The Royal Free Hospital VD Subcommittee Minutes Book (March 10, 1924), H71/RF/A/06/004.

[34] For discussion of pre-war venereological training, see Hanley, *Medicine, Knowledge and Venereal Diseases*, 25–53.

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[41] See, for example, the work of the Leicestershire County Bacteriological Laboratory and the Bacterial Laboratory of the Leicester Royal Infirmary. Records of this work can be found in Leicestershire's *Annual Report of the Medical Officer of Health*.

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[47] Anon., "Measures against Venereal Disease," *BMJ* (December 25, 1920), 978. For more discussion of the Liverpool VD Service, see Caslin, "Transience, Class and Gender:" 1–21.

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[49] Wellcome Library, Medical Women's Federation, Letter from Mary Newton Davis to the MWF (October 19, 1937), SA/MWF/A/4/1.

[50] Birmingham Records Office, Birmingham General Hospital, Correspondence and Papers Relating to the VD Department and Committee (1920–23), HC/GH/1/9/6/7.

[51] Ibid.

[52] Ibid.

[53] Ibid.

[54] Violet Kelynack, "Women Medical Officers at VD Clinics," *BMJ* (October 12, 1929), 694.

[55] Anon., "Standing Committee on Venereal Diseases," *MWF Newsletter* (July 1931), 62–63.

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[57] Ibid, 78 –79.

[58] Martindale, *The Woman Doctor and Her Future*, 83.

[59] Frances Ivens, "An Address to Junior Members," *MWF Newsletter* (March 1925), 16.

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